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FOLLOW-UP ACTIONS TO THE RECOMMENDATIONS OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT: REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

Concise report on world population monitoring, 1996: reproductive rights and reproductive health

Report of the Secretary-General

SUMMARY

The present report has been prepared in accordance with the new terms of reference of the Commission on Population and Development and its topic-oriented and prioritized multi-year work programme, which were endorsed by the Economic and Social Council in its resolution 1995/55.

It provides a summary of recent information on selected aspects of reproductive rights and reproductive health and covers such topics as entry into reproductive life; reproductive behaviour; contraception; abortion; maternal mortality and morbidity; sexually transmitted diseases, including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS); reproductive rights; and population information, education and communication with respect to reproductive rights and reproductive health. The preliminary, unedited version of the full report is available as a working paper in document ESA/P/WP.131.

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INTRODUCTION

1. Reproductive health has been defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes (United Nations, 1995a). Thus, reproductive health goes beyond the child-bearing ages to encompass problems that may arise in both the earlier and the post-reproductive years. Further, reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. The attainment of reproductive health also enables women to go safely through pregnancy and childbirth and provides couples with the best chance of having a healthy infant (United Nations, 1995a).

2. Reproductive rights are central to the achievement of reproductive health. Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights instruments and other consensus documents. The definition of reproductive rights recognizes the basic right of couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to make decisions concerning reproduction, free of discrimination, coercion and violence (United Nations, 1995a). Implicit in this is the right of men and women to be informed about and to have access to safe, effective, affordable and acceptable methods of family planning of their choice.

3. The broad and comprehensive approach to reproductive health reflected in the above definitions contrasts with various previous approaches dealing with reproduction. Those earlier approaches focused on specific aspects of reproductive health. Family planning programmes, for example, have concentrated on providing information and services on contraception. Maternal and child health programmes have similarly focused on promoting the health of mothers and their young children, while safe motherhood programmes have emphasized the need to ensure that pregnant women receive adequate prenatal care, safe delivery and postnatal care. They have also sought to address the high risks that women in many contexts face in relation to child-bearing.

4. Reproductive health incorporates all of those aspects in a comprehensive manner. While acknowledging the importance of family planning, the approach recognizes that reproductive health is not limited to child-bearing ages alone and that reproductive health concerns men as well as women. It also recognizes that to address reproductive health issues successfully, there is a need to address the reproductive rights of men and women and the socia` behaviour and cultural practices that affect reproductive health outcomes.

5. The approach to reproductive health is based on the premise that the health status of individuals at any given time is affected by their experiences at earlier ages. The reproductive health of men and women in child-bearing ages, for example, reflects not only their current experiences but also their health status during infancy, childhood and adolescence. Similarly, health status beyond the reproductive ages may reflect reproductive experiences at earlier

life stages. The experiences of one generation also have implications for the health of the next generation.

6. The present report provides a global review of selected aspects of reproductive rights and reproductive health. The topics covered include entry into reproductive life; reproductive behaviour; contraception; abortion; maternal mortality and morbidity; sexually transmitted diseases, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS); policy issues related to reproductive rights; and population information, education and communication with respect to reproductive rights and reproductive health.

7. To the extent possible, the reproductive rights and reproductive health of both men and women have been reviewed in the present report. However, data collection and research have until recently focused primarily on the reproductive and contraceptive behaviour of women. It is only during the past few years that demographic and health surveys have begun to include samples of men. The need to collect data and to conduct research on the reproductive attitudes and behaviour of both men and women has become more imperative given the renewed emphasis on the shared responsibility of partners in matters related to reproduction. Information is also lacking on the reproductive health of adolescents and of older men and women, who are usually not the subject of inquiry in demographic and health surveys.

I. ENTRY INTO REPRODUCTIVE LIFE

8. Initiation of reproductive capability generally occurs in the second decade of life. The events which define entry into reproductive life, and their timing, are important determinants of both fertility and reproductive health and have important implications for the future life course of individuals. The stage of life during which individuals reach sexual maturity has come to be known as adolescence. Adolescence is the period of transition from childhood to adulthood. Although the change is biological, the duration and nature of adolescence is primarily a social construct and thus varies greatly from culture to culture. This review refers to the age range of 10-24 years but focuses mostly on age group 15-24, which the World Health Organization (WHO) refers to as young people. Within this age span lies much of the variation seen between countries and population subgroups in the events that define the beginning of reproductive life.

9. Adolescence is a period of development that is increasingly recognized both as an important determinant of future health and as a specially vulnerable period of life. In particular, increasing concern has been expressed about sexual risk-taking among young people, and the consequences of such behaviour, such as teenage pregnancy and the occurrence of sexually transmitted diseases, including HIV. The challenges of addressing the needs of adolescents are compounded by demographic factors. It has been estimated that in 1995 young people (ages 15-24 years) make up over 14 per cent of the total population in more developed regions and almost 20 per cent in the less developed regions (United Nations, 1995b).

10. In a number of societies, menarche signifies maturity and the readiness to marry or commence sexual activity. Studies documenting the age at menarche show that the age of onset varies by approximately five years between different population groups. The average age for each region indicates a younger age at onset in the more developed than in the less developed regions. Age at menarche has fallen in most developed countries. In developing countries, the decline is less well documented, but there is some evidence of a fall in age at onset in a number of population groups. The fall in age at menarche implies an earlier potential to reproduce. However, in general, it would appear that the effect of this biological factor has been offset by other influences, especially by increases in age at first marriage.

11. Traditionally, age at marriage has been regarded as marking the initiation of sexual activity and, therefore, the beginning of exposure to reproduction. Marriage may take widely different forms, ranging from formal unions approved under civil or religious law, to cohabiting or even visiting relationships. Despite the difficulties surrounding definitions of marriage, it is possible to identify some broad patterns in the timing of the beginning of sexual exposure of young women and men by examining the age at marriage.

12. Changes in the timing of first marriage around the world are well documented and it is clear that age at first marriage among women has risen dramatically in many countries. In the developing countries with data from the Demographic and Health Surveys (DHS), changes in the age at marriage can be examined by comparing the experience of women in different cohorts. The surveys use a broad definition of marriage which includes both formalized and informal unions. The data indicate that the proportion married by age 20 among young women (those aged 20-24 at the time of the survey) is considerably lower than that among older women (aged 40-44 at the time of the survey) in nearly all countries. The shift towards later marriage is most pronounced in the Asian countries: taking the average for eight countries shows that 57 per cent of women currently aged 40-44 years first married before age 20; the corresponding figure for women currently aged 20-24 years is 37 per cent. In Africa, the reduction in the average proportion married by age 20 has been almost as sharp - from 72 per cent to 55 per cent - but the prevalence of teenage marriage remains much higher than in Asia. In Latin America and the Caribbean, changes in the timing of first marriage have been more modest and the average proportion married before age 20, 42 per cent, is somewhat higher than in Asia.

13. Age at marriage for women has also risen in the past 20 years in the developed countries, although information on trends in age at marriage is not comparable to that for developing countries because most data derived from civil registration deal with legal marriage only. In 1970, the typical average age at first marriage in Northern and Western Europe was 22-23 years. By 1990, age at marriage in many countries in Northern and Western Europe had risen to 25-27 years. Increases are also observed in Northern America. In Eastern and Southern Europe changes in marriage ages have been more modest.

14. In most countries there is a general trend towards later marriage with increased educational level. Urban-rural residence represents a further influence on marriage ages for women. DHS data show that women with at least 10 years of education marry between two and seven years later than those with

less than primary education. Women living in urban areas typically marry later than their rural counterparts although the urban-rural gap varies considerably. In many developing countries, there is a 20 per cent or larger difference in the proportion marrying by age 20. In others, the difference is small.

15. Differences in the age at marriage between men and women have narrowed over time in many countries in Africa, most notably in Northern Africa, Asia and many countries in Latin America and the Caribbean. The convergence has been most marked in countries where differences were the largest. In Northern America and Europe, the gaps between the sexes have contracted further in recent decades.

16. In Europe, the upward trend in age at marriage has coincided with an increase in the proportion cohabiting. Recent data show that at ages 15-19, the proportions cohabiting range between nearly zero and 20 per cent. The prevalence of cohabitation peaks at ages 20-24, with a range of approximately 10-40 per cent, and declines thereafter. The major reason for the decline in informal cohabitation after age 25 is the growing dominance of legal marriage. Cohabitation may thus be a prelude or an alternative to marriage.

17. Delays in the timing of first marriage have played a key role in the fertility decline in many countries because most births continue to occur within marriage. Increases in the age at marriage, however, do not necessarily translate into the shortening of the reproductive life span. Premarital births are increasing in a number of countries around the world. Furthermore, the prevalence of sexually transmitted diseases among unmarried adolescents suggests that premarital sexual activity is not uncommon and may be increasing.

18. A growing body of survey data reveals wide variability in sexual behaviour among young people. In some areas of the world sexual activity begins early and is frequently premarital, while in others it is dictated by strong social sanctions and commonly coincides with marriage, although this, too, may occur at a very early age. Despite the paucity of systematic data and the variability in sexual behaviour of young people, some broad patterns emerge from the evidence.

19. In most areas of the world, men report an earlier age at sexual initiation than women, a greater number of partners and a longer period between sexual initiation and marriage. They are more likely than women to report premarital sexual activity. Age differences between partners have important implications for transmission of sexually transmitted diseases. Men typically have younger female partners, which increases the vulnerability of younger women to sexually transmitted diseases and HIV infection. Relationships between older men and younger women are reported to be increasingly common in some parts of Africa.

20. In the industrialized countries, there are indications of an increase in the overall proportion of young people who are sexually active. Age at marriage has increased; there is evidence of a fall in the age at sexual initiation; and a greater proportion of adolescents are involved in cohabiting relationships.

21. In sub-Saharan Africa and Latin America and the Caribbean, age at marriage has increased. Age at sexual initiation appears to have remained unchanged, although sexual activity begins at an early age in many countries. Increases in

age at marriage, in the absence of changes in age at sexual initiation, have meant that more young people have been exposed to premarital sexual activity.

22. Little is known about the sexual behaviour of young people in Asia. It is typically assumed that premarital sexual activity is uncommon and is subject to strong societal constraints. Evidence is sparse but a few studies indicate that sexual initiation coincides with marriage for the majority of young women, or is a prelude to marriage. Thus, any rise in age at marriage will also increase the age at sexual initiation.

II. REPRODUCTIVE BEHAVIOUR

23. The current total fertility rate (TFR) for the world as a whole is estimated to be 3.1 children per woman (United Nations, 1995b). This average, however, conceals a large diversity between and within regions. The gap between the more developed regions (TFR of 1.7) and the less developed regions (TFR of 3.5), although narrower than in the past, remains sizeable. The highest TFR is observed in Africa (5.8), followed by Latin America and the Caribbean (3.1) and Asia (3.0). At the country level, current fertility rates range from 7.6 in Yemen to 1.2 in Italy and Spain.

24. During the past decade, fertility has continued its downward trend. At the world level, the average number of children per woman declined from 3.6 in 1980-1985 to 3.1 in 1990-1995. The underlying change in reproductive behaviour, however, differs greatly by region. In the more developed regions, fertility, which has been below replacement since the late 1970s, experienced only a slight decline, whereas in the less developed regions fertility fell from 4.2 to 3.5. The observed reduction was more modest in the least developed countries, where fertility declined from 6.4 to 5.8 children.

25. In recent decades, adolescent child-bearing has emerged as an issue of increasing concern throughout the developing and the developed world. There is a growing awareness that early child-bearing poses a health risk for the mother and the child and may truncate a girl's educational career, threatening her economic prospects, earning capacity and overall well-being.

26. It is estimated that world wide about 15 million girls aged 15-19 give birth each year and that about 11 per cent of all babies are currently born to adolescents (United Nations, 1995b). There is, however, considerable variation across regions. The level of adolescent fertility in the least developed countries (140 births per 1,000 women under age 20) is twice as high as that in developing countries (65 births per 1,000) and four times higher than that in the developed countries (32 births per 1,000). Within the developing regions, adolescent fertility rates are highest in Africa (136 births per 1,000), followed by Latin America and the Caribbean (79 births per 1,000) and lowest in Asia (45 births per 1,000). High rates of adolescent child-bearing are generally linked to a pattern of early marriage.

27. Although adolescent fertility is increasingly perceived as an issue of social and policy concern, fertility rates among women under age 20 have been falling alongside overall fertility rates world wide, owing to rising age at

marriage, increasing educational opportunities for young women and increased use of contraception. There are, however, some exceptions to the overall downward trend, for example in Haiti, India and the United States of America.

28. Education has long been recognized as a crucial factor influencing reproductive behaviour. According to a recent United Nations study, female education is universally associated with lower fertility (United Nations, 1995c). Countries in Latin America display the largest fertility gaps between better educated and uneducated women, ranging from 3 to 5 children per woman. Fertility differentials by education are not uniform across countries, suggesting that the resultant effect of women's education is conditioned by socio-economic development, social structure and cultural context. In contemporary developing societies, the impact of individual schooling on child-bearing tends to become stronger as the socio-economic conditions and the overall educational level of the society improve.

29. The timing of the onset of child-bearing has important implications for individuals, families and societies. In most countries, women's average age at first birth occurs within one and two years after first marriage. However, marriage is not the only context within which child-bearing takes place. In many developed countries, the rapid increase in child-bearing outside marriage, closely linked to the rise in cohabitation, constitutes one of the most significant recent transformations in family-building patterns. In the developing regions, out-of-wedlock child-bearing is relatively rare in Asia, but commonplace in Africa and Latin America and the Caribbean, reflecting the high prevalence of consensual unions.

30. The timing of entry into motherhood is remarkably similar across a wide range of developing societies: it tends to occur between ages 19 and 22. In most developed countries, entry into motherhood occurs at a later age, usually between ages 22 and 27. The trend observed during the past decade in both developing and developed societies has been towards a delayed pattern of family formation. The duration of women's child-bearing span, that is, the average number of years between women's first and last birth, is longest in Africa (ranging from 15 to 20 years), followed by Asia (11 to 17 years) and Latin America and the Caribbean (11 to 16 years).

31. Fertility preferences vary considerably across regions. Desired family size is largest in sub-Saharan Africa (where it ranges from four to eight children), followed by Asia (three to five children), Northern Africa (three to four children) and Latin America and the Caribbean (three to four children). The observed trend points towards women's increasing preference for smaller families.

32. The prevailing gap between women's ideal family size and actual child-bearing suggests that women's reproductive aspirations are seldom fulfilled. The inadequate control women have over their reproduction is also evident from the high prevalence of unplanned child-bearing. The percentage of births reportedly unwanted ranges from 2 to 26 in Africa, 6 to 21 in Asia and 5 to 35 in Latin America and the Caribbean, and the percentage of births reportedly mistimed ranges from 6 to 52 in Africa, 8 to 28 in Asia and 13 to 25 in Latin America and the Caribbean.

33. In the developed countries, a family with two children is the dominant ideal and, in many cases, the preferred number of children is above the actual total fertility rate. However, the number of unintended births is relatively large, despite the high prevalence of contraceptive use. In the United States, for example, 12 per cent of all births were reported as unwanted and 27 per cent as mistimed.

34. Between 8 and 12 per cent of all couples experience some form of infertility during their reproductive lives, a problem affecting 50-80 million people world wide (WHO, 1991). In a small proportion of couples (under 5 per cent) the underlying causes of infertility are attributable to anatomical, genetic, endocrinological or immunological factors. However, in the majority of cases, problems of infertility arise from preventable causes, such as untreated infection from sexually transmitted diseases, post-partum and post-abortion complications or female genital mutilation.

35. Past studies have documented unusually high incidence of impaired fertility in Africa, particularly in Central Africa. However, recent DHS data do not detect high levels of primary infertility: the proportion of childless women among ever-married women aged 40-44 does not exceed 6 per cent in any of the surveyed countries. The prevalence of disease-induced sterility in Africa, however, is significantly higher when secondary infertility is examined: the proportion of women aged 30-34 subsequently infertile is estimated to be above 20 per cent in Benin, Botswana, Côte d'Ivoire, Ghana, Liberia, Mali, Mauritania, Nigeria, Senegal, the Sudan, Uganda and Zimbabwe and above 30 per cent in Cameroon (Larsen, 1994).

36. A number of factors associated with the pattern of child-bearing may adversely affect the survival and well-being of mothers and children. Pregnancies too early or too late in the maternal life course, high-parity pregnancies and closely spaced pregnancies are considered to pose higher-than-normal risks to children's and women's health. DHS data reveal that the percentage of births subject to these risks is remarkably high, ranging from 53 to 73 in Africa, 38 to 79 in Asia and 46 to 66 in Latin America and the Caribbean. High parity is the most common risk factor, followed by short birth interval.

37. Although changes in the age, parity and birth-spacing distributions of fertility have the potential of reducing maternal mortality, the majority of women who die from pregnancy, abortion or childbirth do not fall within these high-risk categories. Socio-economic conditions, education, nutrition and health care are often more important determinants of women's health and survival. Coverage of maternity services varies greatly between countries. In 15 out of 44 developing countries, the proportion of births for which women received antenatal care was below two thirds, and in 17 out of 45 countries, less than half of the deliveries were assisted by a trained professional.

III. CONTRACEPTION

38. Family planning is an integral part of reproductive health. Since the 1960s there has been a sustained increase in the use of contraception in developing countries. In the early 1960s, when TFR in the less developed regions averaged 6.1 children per woman, the level of contraceptive prevalence - current use among couples with the woman of reproductive age - was probably under 10 per cent in the developing countries, while recent surveys show that contraceptive prevalence in those regions had risen to 53 per cent by 1991. In developed countries, contraceptive prevalence averaged 71 per cent, and for the world as a whole the average was 57 per cent (see table 1). The level of contraceptive use in Africa, at 19 per cent, is far below the average level for the other developing regions: 79 per cent in Eastern Asia; 43 per cent in the remainder of Asia and Oceania; and 59 per cent in Latin America and the Caribbean.

Table 1 Average prevalence of specific contraceptive methods, by region a/

(Percentage of couples with the woman in the reproductive age)

Major area and region	All methods (1)	Modern methods b/ (2)	Sterilization Female (3)	Sterilization Male (4)	Pill (5)	Injectable (6)	IUD (7)	Condom (8)	Vaginal barrier methods (9)	Rhythm (10)	Withdrawal (11)	Other methods (12)
World	57	49	18	4	8	1	12	5	1	3	4	1
Less developed regions	53	48	21	4	6	2	13	2	0.2	2	2	1
Africa	19	15	1	0.1	7	2	4	1	0.2	2	1	1
Asia and Oceania c/	58	54	24	5	5	2	16	2	0.2	2	2	0.1
Eastern Asia c/	79	79	33	9	3	0.1	31	2	0.3	0.4	0.1	.
Other countries	43	36	17	2	6	3	5	3	0.1	3	3	1
Latin America and the Caribbean	59	49	21	1	17	1	6	2	1	6	3	0.5
More developed regions d/	71	51	8	5	17	0.1	5	14	2	6	12	1

Source: World Population Monitoring, 1996 (United Nations publication, forthcoming).

Note: These estimates reflect assumptions about contraceptive use in countries with no available data.

a/ Based on the most recently available survey data; average date 1991.

b/ Including methods in columns 3-9.

c/ Excluding Japan.

d/ Australia-New Zealand, Europe, Northern America and Japan.

39. The transformation in contraceptive practice reflects the growing desire of couples and individuals to have smaller families and to choose when to have their children. It also reflects the great increases in the availability of effective modern contraceptives in developing countries and of associated family planning information and services. Although the recent changes in the developed regions concern primarily the choice of specific birth control methods rather than the overall level of contraceptive use, the introduction of modern methods has also brought about a transformation in contraceptive practice.

40. Most users of contraception are women and most of them use modern methods. Relatively effective clinic and supply ("modern") methods account for an estimated 87 per cent of contraceptive use worldwide. The three main "female" methods - female sterilization, intra-uterine devices (IUDs) and oral pills - account for over two thirds of contraceptive practice world wide and three fourths of use in the less developed regions. Modern methods in general make up a larger fraction of contraceptive use in the developing than in the developed countries, estimated at 91 per cent and 73 per cent, respectively. Prevalence of clinic and supply methods averages 51 per cent in the more developed regions and 48 per cent in the less developed regions. The prevalence of non-supply and traditional methods differs more between the developed and the developing countries, 20 per cent and 5 per cent, respectively. This group of methods includes periodic abstinence or rhythm, withdrawal (coitus interruptus), abstinence, douching and various folk methods. The higher levels of use of these methods in the developed countries reflects the continuing influence of patterns of fertility control established before the era of modern contraceptive methods and also the lack of wide availability of newer methods in some countries. Some developed countries where the use of traditional methods was widespread around 1970 have undergone a marked transition to the use of modern methods: Belgium, France and Hungary are examples. However, some countries in Eastern Europe with surveys conducted in the 1990s still show high prevalence levels of traditional methods: examples include the Czech Republic, Romania and Slovakia.

41. Most developing countries with available trend data show a substantial recent increase in contraceptive use. Consideration of trends between the most recent available survey and surveys conducted about 10 years earlier, shows that increases in contraceptive use have been the most rapid in countries that had a moderate level of use at the start of the period. Where prevalence was in the range of 15-50 per cent, the level of contraceptive use subsequently grew by more than 1.0 per cent per annum in over 80 per cent of the countries. By contrast, annual increases of 1.0 points or more occurred in about 55 per cent of the developing countries where prevalence was initially either below 15 per cent or above 50 per cent. Although the average level of contraceptive use remains much lower in Africa than in other developing regions, surveys conducted in the past few years have continued to add to the evidence of increasing use of contraception in continental sub-Saharan Africa.

42. With respect to the use of particular types of contraception, rising use of female sterilization is the most important trend in both developed and developing countries. None the less, there are many individual countries where other methods are responsible for most of the recent trend. While there is a general tendency for modern methods as a group to become more predominant over time, there is little sign that the widely varying national patterns of use are converging to the same method mix. Only rarely does a single type of contraception account for most of current use.

43. Recent surveys indicate a significant rise in the level of use of condoms in several countries, suggesting that campaigns promoting this method are having an effect. On average, condoms account for only about 8 per cent of contraceptive practice reported by married women. However, men tend to report more use of this method than do women. Levels of condom use among unmarried men

are usually higher than among married men, even though the general level of contraceptive use is higher among the married men.

44. Despite the recent rapid growth in the use of contraception, a variety of indicators suggest that the level of unmet need remains high, with about 20-25 per cent of couples in developing countries (except China) at risk of an unwanted or mistimed pregnancy, but not using contraception. In Africa and in some countries in other regions, substantial proportions of the population still have no knowledge of any type of contraception. Furthermore, the percentage of women who know of a place to obtain family planning information or services is sometimes much lower than the percentage of those who have heard of a method. In Asia and Northern Africa, 90 per cent or more of women knew of a service outlet in over three fourths of the countries with available data, and in Latin America and the Caribbean this level was reached in about 60 per cent of countries. However, this level of knowledge of services was observed in only 2 of 23 countries in sub-Saharan Africa (Botswana and Zimbabwe).

45. In general, problems of limited knowledge of and access to family planning reflect the difficulty many Governments have experienced in extending services nationwide rather than a deliberate policy to restrict access. By 1995, only two Governments (out of 190) had an official policy of limiting access to modern contraceptive methods, while 82 per cent of the Governments provided direct support for family planning services. Ratings of various aspects of family planning policy and programme performance carried out in 1982, 1989 and 1994 indicate that there was rapid growth in programme effort and method availability during the 1980s. A further increase was noted in many countries since 1989, but at a slower pace than between 1982 and 1989. Based on knowledgeable observers' ratings of the availability of five types of contraception, in 1994 condoms were estimated to be readily available to about two thirds of the population of developing countries, and oral pills, IUDs and female sterilization to about 60-65 per cent. Male sterilization was judged to be readily available to slightly less than 50 per cent of the population. Despite substantial recent improvements, contraceptive methods are much less readily available in sub-Saharan Africa than in other regions.

46. In most developing countries levels of contraceptive use are substantially higher among urban and well-educated women than among their rural and less educated counterparts. During the past 10-15 years, the average size of the social differentials in contraceptive practice has changed very little, although this is partially due to offsetting changes in different countries. Where contraceptive use had been low to start with, differentials usually widened, and the reverse was true in countries where use levels were already high at the earlier date in urban areas or among highly educated women.

47. Many surveys have limited questions about current contraceptive use to married women. Recently, more surveys have posed these questions to unmarried women, and these data show that an exclusive focus on married women leaves out a significant proportion of contraceptive users in many cases. In sub-Saharan Africa and in the more developed regions with such information available, women not in a union make up about one fourth of all contraceptive users, on average, and in Latin America and the Caribbean nearly 10 per cent.

48. While some couples use a single contraceptive method successfully for many years, most are likely to stop contraceptive use or switch from their first method at some point. Studies of contraceptive discontinuation show that within a year of starting to use the pill, typically 40-60 per cent of women will have stopped, 15-30 per cent for IUD, more than 50 per cent for the condom and about 40-60 per cent for periodic abstinence (including the calendar rhythm method). Reasons for stopping vary by method. In general, methods that are highly effective at preventing pregnancy have a high incidence of side-effects and vice versa.

49. Side-effects and worries about them stand out consistently in studies of different populations as one of women's major concerns about modern contraceptive methods. Health concerns and side-effects are frequently cited as the reason for discontinuing the methods, and in many cases a substantial proportion of women who are at risk of an unwanted pregnancy report that health concerns are their main reason for not using contraception. At the same time, the recent rise in the level of contraceptive use is due almost entirely to increased use of modern methods. The evidence suggests that, although modern methods have worked well for many couples, their use still presents difficult choices for many others. The rapidly increasing reliance on the permanent method of surgical sterilization must be in part a reflection of the drawbacks of the temporary methods and services that are currently available.

50. Although most information about contraceptive use and unmet need is derived from surveys of women, recently more surveys have asked men about these topics. This information is only now beginning to be analysed in detail. In some countries a substantial proportion of the women with an apparent unmet need for contraception report that they are not using any method because of opposition from their spouse, which could refer either to opposition to contraception in general or to a disagreement about the number and timing of children. The available evidence about disagreements between spouses points to a variety of situations whose relative importance is often impossible to quantify. Some men clearly do expect to make the choice about using contraception (even if it is the woman who uses the method), while others view this as being completely the woman's responsibility. In some countries, many people do not know their partner's views about family planning. The question of how inter-spouse disagreements are resolved in practice deserves more attention than it has received to date, and this requires obtaining comparable information from both men and women.

IV. ABORTION

51. Approximately 25 million legal abortions were performed world wide around 1990, or one legal abortion for every six births. This estimate must be considered the minimum number of legal abortions, as no attempt has been made to estimate the magnitude of unreported legal abortions. Given the clandestine nature of unsafe abortion, its incidence is very difficult to gauge. WHO has estimated that some 20 million unsafe abortions are performed each year, or one unsafe abortion for every seven births (WHO, 1994). Thus, at a minimum, some

45 million abortions a year are thought to be taking place globally, that is, nearly one abortion for every three live births.

52. Induced abortion has attained high public visibility in many countries, both developed and developing. In some cases, public concern has been voiced primarily because of the alarmingly high levels of maternal mortality and morbidity that have resulted from unsafe abortion. In others, the visibility has resulted more from public debate concerning the moral and legal status of abortion and the role that the State should play in permitting or denying access to induced abortion.

53. At the International Conference on Population and Development in 1994, the issue of abortion proved to be one of the most contentious, with much of the debate dealing directly or indirectly with various abortion-related issues. At the end of the debate, delegations agreed on the following wording: "In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion 1/ as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services ..." (United Nations, 1995a, Chap. I, resolution 1, annex, para. 8.25).

54. Induced abortion is one of the oldest methods of fertility control and one of the most widely used (United Nations, 1992, 1993 and 1995d). It is practised both in remote rural societies and in large modern urban centres and in all regions of the world, although with differing consequences. In countries where abortion is legal and widely available, abortions generally pose a relatively small threat to women's reproductive health. Where abortion is illegal, however, it is usually performed in medically substandard and unsanitary conditions, leading to a high incidence of complications and resulting in chronic morbidity and often death. Indeed, WHO has estimated that more than 70,000 women die annually as a result of complications arising from unsafe abortion. Moreover, long-term consequences of unsafe abortion may include chronic pelvic pain, pelvic inflammatory disease, tubal occlusion, secondary infertility and increased risk of spontaneous abortion in subsequent pregnancies (WHO, 1994).

55. Substantial variations exist in incidence of unsafe abortion by region. The incidence of unsafe abortion varies from a high of 30 or more unsafe abortions per 1,000 women aged 15-49 years in Eastern and Western Africa, Latin America and the Caribbean and the former USSR to fewer than 2 unsafe abortions per 1,000 women aged 15-49 years in Northern Europe and Northern America (WHO, 1994). Some of the variations in the incidence of unsafe abortion can be explained by the less restrictive nature of abortion laws in Northern Europe and Northern America (11 of 12 countries permit abortion on request or for economic or social reasons), as compared with Eastern and Western Africa and Latin America and the Caribbean (2 of 45 countries permit abortion on request or for economic or social reasons). Lack of legal restrictions on abortion, however, does not necessarily guarantee access to safe abortion, as evidenced by the relatively high incidence of unsafe abortion in the former USSR (estimated by WHO at 30 unsafe abortions per 1,000 women aged 15-49 years), despite the availability of abortion on request since 1956.

56. In line with the heightened interest in adolescent reproductive behaviour, adolescent abortion is a growing area of concern. Because adolescents are sometimes unwilling or unable to seek appropriate health care or wait longer in the gestation period to obtain help, induced abortion generally presents a greater risk to the health and life of the adolescent than to an adult woman. According to recent United Nations estimates, abortion among adolescents has accounted for 15-25 per cent of total reported legal abortions in a number of developed and developing countries.

57. Based on information available for 193 countries, the overwhelming majority of countries (98 per cent) permit abortions to be performed to save the pregnant woman's life (United Nations, 1992, 1993 and 1995d). In a number of those countries, criminal laws specifically allow abortion on this ground. In others, however, one must look to other laws or court decisions to determine if there are exceptions to a general prohibition of abortions. For example, in Honduras, the Code of Medical Ethics permits abortion to save the woman's life; in Nepal, the rules of the Medical Council have been interpreted to permit abortion in various situations; and in Ireland the Supreme Court has ruled that an abortion can be performed to preserve the life of the pregnant woman. In yet other countries, the criminal law principle of necessity can be invoked to exempt from punishment the performance of an abortion to save a pregnant woman's life. Examples include the Central African Republic, the Dominican Republic, Egypt and the Philippines.

58. Abortion to preserve the woman's physical health is permitted in 119 countries (62 per cent). Fewer countries (95, or 50 per cent) allow abortion to preserve the woman's mental health, and 81 countries (42 per cent) permit it when pregnancy has resulted from rape or incest. The number declines to 78 countries (40 per cent) when there is the possibility of foetal impairment and to 55 countries (29 per cent) when there are economic or social reasons. Finally, in 41 countries (21 per cent), abortion is available on request.

59. An examination of abortion policies in terms of population discloses that 96 per cent of the world population lives in countries that permit abortion to save the woman's life, 75 per cent lives in countries permitting abortion to preserve the woman's physical health, 69 per cent in countries where abortion is legal to preserve the woman's mental health and 72 per cent in countries where abortion is allowed when the pregnancy results from rape or incest. The percentage declines to 64 when there is the possibility of foetal impairment and to 44 in countries that permit abortion for economic or social reasons. Finally, abortion is available on request to 38 per cent of the world population.

V. MATERNAL MORTALITY AND MORBIDITY

60. Among the health and mortality indicators, levels of mortality show striking disparities according to levels of development. Maternal mortality is a sensitive indicator of the status of women in society, their access to health care and the adequacy of the health care system in responding to their needs. Information about levels and trends of maternal mortality is needed, therefore, not only to assess the risks of pregnancy and childbirth, but also for what it

implies about women's health in general and, by extension, their social and economic well-being.

61. It is extremely difficult to assess levels of maternal mortality at the national level. Doing so requires knowledge about deaths of women of reproductive age (15-49 years), the cause of death and also whether or not the woman was pregnant at the time of death or had recently been so. Yet, few countries register all births and deaths; even fewer register the cause of death; and fewer still systematically note pregnancy status on the death form.

62. Inevitably, countries with the least developed systems of vital registration are those with the worst health indicators. In such circumstances, alternative ways have to be developed for estimating levels of maternal mortality. A variety of innovative methodologies have been devised to overcome the absence of data in countries with poor or non-existent vital registration. For example, maternal mortality can be measured by incorporating questions on pregnancy and deaths into large-scale household inquiries, but this approach requires a large sample size and is expensive and time-consuming. A more cost-effective approach is the "sisterhood method", which adds on to existing household surveys a few simple questions about whether or not the sisters of the respondent are still alive. Much smaller sample sizes are needed because each respondent can provide information on a number of sisters. However, the results do not provide current estimates but give an idea of the levels of maternal mortality roughly 10 years earlier.

63. The best way to measure maternal mortality in the absence of vital registration is to identify and investigate the causes of all deaths of women of reproductive age - the Reproductive Age Mortality Survey (RAMOS). Multiple sources of information - civil registers, health facility records, community leaders, religious authorities, undertakers, cemetery officials, schoolchildren - must be used to identify all deaths. Subsequently, interviews with household members, health-care providers and facility records are used to classify deaths as maternal or otherwise (verbal autopsy). Although RAMOS studies are considered to be the "gold standard" for estimating maternal mortality, they are also time-consuming and complex to undertake, particularly on a large scale.

64. Because of the difficulties and costs involved, only nine developing countries have carried out RAMOS or household studies to estimate maternal mortality at the national level. In such circumstances, other methods have to be devised to provide broad estimates of the extent of the problem. WHO and UNICEF have developed new estimates of maternal mortality using a simple modelling strategy. This is based on existing data sets and uses two independent variables - general fertility rates and proportion of births that are assisted by a trained person - to predict values for countries with no sound national estimate of maternal mortality.

65. The model is primarily intended to be of use in countries with no estimates of maternal mortality or where there is concern about the adequacy of officially reported estimates. It provides figures on orders of magnitude rather than precise estimates of maternal mortality. The standard errors associated with the predicted maternal mortality ratios are very large. Moreover, the ratios

generated from the modelling exercise cover a 10-year time span (roughly 1982-1992). They cannot, therefore, be used for regular monitoring of trends. The figures pertain to around 1990 and should be seen as a recalculation of the earlier 1991 revision prepared by WHO rather than as indicative of trends since then.

66. Preliminary results of the new model are shown in table 2. The results indicate that maternal mortality is higher than previously estimated, with some 590,000 maternal deaths compared with 509,000, according to the earlier model. The most significant differences between the old and the new model are for Africa, where the maternal mortality ratio according to the new estimates is 878 per 100,000 live births, compared with the earlier estimate of 630 per 100,000. By contrast, the estimates produced by the new model for Asia and Latin America and the Caribbean show relatively small changes compared with the earlier model.

Table 2. Estimates of maternal deaths and maternal mortality ratios, 1990

Major area and region	Maternal deaths	
	Number (thousands)	Ratio (per 100,000 live births)
World	590	429
More developed regions	4	27
Less developed regions	586	479
Africa	238	878
Asia	323	383
Europe	3.2	36
Latin America and the Caribbean	23	194
Northern America	0.5	11
Oceania	2.0	382

Source: World Health Organization, Maternal Mortality Ratios and Rates: A Tabulation of Available Information, 4th ed. (Geneva, forthcoming).

67. If counting the total numbers of maternal deaths is difficult, estimating the causes of those deaths is even more so. Few studies collect information on the cause of death in a standard format or follow the categories of causes of death described in the International Classification of Diseases. However, based on the evidence of the few good community-based studies, it is possible to estimate the breakdown of maternal mortality by five major causes of death. A summary of the incidence of and mortality from the five major obstetric complications is given in table 3. There are significant regional variations

within these global totals. Abortion is likely to account for a larger percentage of overall maternal mortality in Latin America although the maternal mortality ratio is generally lower in that region than in most parts of Africa.

Table 3. Estimated global incidence and mortality from main obstetric complications world wide, 1990

Obstetric complications	Number of cases a/ (thousands)	Number of deaths (thousands)	Percentage of all maternal deaths
Haemorrhage	14 300	150	25
Sepsis	12 000	90	15
Hypertensive disorders of pregnancy and eclampsia	7 100	75	13
Obstructed labour	7 300	40	7
Unsafe abortion	19 900	75	13
Other direct causes	3 600	50	8
Indirect causes	13 500	110	19
Total	77 600	590	100

Source: World Health Organization, Maternal Health and Safe Motherhood Programme (Geneva), unpublished estimates.

a/ Estimated number of events, not women.

68. In these calculations it has been assumed that each complication is a discrete event and, therefore, that complications arise in some 56 per cent of pregnancies ending in live birth. The severity of the complication will, of course, vary and WHO estimates that almost 15 per cent of all women develop complications serious enough to require rapid and skilled intervention if the woman is to survive without lifelong disabilities. Such disabilities include obstetric fistula (damage to the bladder and/or rectum); reproductive tract infections; pelvic inflammatory disease; infertility; anaemia; prolapse; and damage to the brain, kidneys and cardiovascular system.

69. The complications that cause the deaths and disabilities of mothers also damage the infants they are carrying (see table 4). Of the approximately 8 million infant deaths each year, almost two thirds occur during the neonatal period, before the baby is one month old. Every year there are 5 million neonatal deaths, of which 3.5 million occur within the first week of life and are largely a consequence of inadequate or inappropriate care during pregnancy, delivery or the first critical hours after birth. And for every newborn death another infant is stillborn.

Table 4. Effect of pregnancy complications on mother and baby

Problem or complication	Most serious effects on mother's health	Most serious effects on newborn baby-foetus
Severe anaemia	Cardiac failure	Low birth weight, asphyxia, stillbirth
Haemorrhage	Shock, cardiac failure, infection	Asphyxia, stillbirth
Hypertensive disorders of pregnancy	Eclampsia, cerebrovascular accidents	Low birth weight, asphyxia, stillbirth
Puerperal sepsis	Septicaemia, shock	Neonatal sepsis
Obstructed labour	Fistulae, uterine rupture, prolapse, amnionitis, sepsis	Stillbirth, asphyxia, sepsis, birth trauma, handicap
Infection during pregnancy, sexually transmitted diseases	Premature onset of labour, ectopic pregnancy, pelvic inflammatory disease, infertility	Premature delivery, neonatal eye infection, blindness, pneumonia, stillbirth, congenital syphilis
Hepatitis	Postpartum haemorrhage, liver failure	Hepatitis
Malaria	Severe anaemia, cerebral thrombosis	Prematurity, intra-uterine growth retardation
Unwanted pregnancy	Unsafe abortion, infection, pelvic inflammatory disease, haemorrhage, infertility	Increased risk of morbidity, mortality; child abuse, neglect, abandonment
Unclean delivery	Infection, maternal tetanus	Neonatal tetanus, sepsis

70. Aside from considerations of the numbers of deaths and disabilities, there is also the issue of the nature of a maternal death. The mothers who die are in the prime of life, at the summit of their social and economic productivity. They leave behind them families, many with young children, who must survive without the support of the prime caregiver, producer of food and generator of income.

71. The paucity of information about maternal ill-health has resulted in long neglect of the problem, neglect that the international community has only recently started to address. There is still much that has to be learned, not about the interventions needed to reduce maternal deaths, which have been known for many years, but about how to implement those interventions in a sustainable way in resource-limited settings. Although maternal mortality and morbidity are

major components of reproductive ill-health, addressing them requires interventions that differ, in several important ways, from the interventions needed to deal with other components of reproductive ill-health. In particular, it will not be possible to achieve sustainable reductions in maternal mortality in the absence of functioning district health systems, including widespread availability of maternal health care at the community level along with appropriate referral and management of complications and emergencies.

VI. SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV/AIDS

72. Until recently, the prevention and control of sexually transmitted diseases was a low priority for most countries and development agencies. Lack of awareness of the problem of sexually transmitted diseases and their complications and sequelae, competition for resources to control other important health problems and reluctance of public health policy makers to deal with diseases associated with sexual behaviour have all played a role in this neglect.

73. To date, most programmes for the prevention of sexually transmitted diseases have focused on prevention of complications (secondary prevention). The prevention of transmission of infection (primary prevention) is at present receiving increased attention because of the global HIV/AIDS epidemic and the identification of several sexually transmitted diseases as risk factors for the spread of HIV.

74. Currently in its second decade, the HIV epidemic continues to grow with thousands of new infections occurring every day. An estimated cumulative total of 18.5 million adults and 1.5 million children have been infected with HIV. Of all the infected cases, 7-8 million are women, about 70 per cent of whom are of child-bearing age. According to WHO, between 13 million and 15 million infected adolescents and adults, in addition to about half a million infected children, are alive today.

75. The longer-term dimensions of the HIV/AIDS pandemic cannot yet be forecast with confidence. However, on the basis of the available data on the current global status of the pandemic and recent trends in its spread, WHO has generated a plausible range of projected new HIV infections during the 1990s. In making projections of the future magnitude of the pandemic, WHO uses the lower limit of its estimated range of the HIV prevalence for each region. The results should thus be considered conservative.

76. During the current decade, WHO forecasts that about 10-15 million new cases of HIV infections may be expected in adults, mostly in developing countries. During the same period, WHO projects that as many as 5-10 million children will be HIV-infected through their mothers, the majority of them in sub-Saharan Africa. By the year 2000, 30-40 million HIV infections will have occurred, 90 per cent of which will be in developing countries. The projected cumulative total number of HIV-related deaths is predicted to rise to more than 8 million from its current total of 2 million. WHO also estimates that over 5 million children under age 10 years will be orphaned by the end of the 1990s as a result of the HIV-related deaths of their parents. The number of orphans will increase

further in the early years of the twenty-first century as a result of the death of those mothers who were infected with HIV in the 1990s.

77. The epidemic is having devastating effects on individuals, families and entire communities. For women, HIV infection has added its burden to risks related to sexually transmitted diseases, pregnancy and childbirth. The proportion of women with HIV and AIDS has increased, especially in developing countries. Young people are particularly affected by HIV and AIDS. It is estimated that 50 per cent of HIV infections occur in age group 15-24. This has an important impact on the economy of many countries since the age groups most affected - young and middle-aged adults - constitutes the bulk of the workforce. The socio-economic burden of sexually transmitted diseases, in terms of direct and indirect costs, is increasing rapidly.

78. Over the past 10 years, the response to HIV/AIDS has focused on prevention, as well as on care. Governments, non-governmental organizations, communities, associations and networks of people living with HIV/AIDS, international organizations and the health, education and other sectors, as well as the public and private sectors, have worked in partnership to develop a response to the epidemic.

79. The epidemiological trends of sexually transmitted diseases in various parts of the world are strikingly different. In the developing countries the epidemic is characterized by high incidence and prevalence; a high rate of complications; an alarming problem of anti-microbial resistance; and the interaction with HIV infection. It is estimated that about 333 million curable cases of sexually transmitted diseases occur globally every year, most of which are occurring in developing countries.

80. Sexually transmitted diseases have been a neglected area in public health in most of the developing countries despite the overwhelming facts of their impact on health, particularly for women and newborns. For several decades, sexually transmitted diseases have ranked among the top five conditions for which adults in many developing countries seek health-care services. In most industrialized countries, on the other hand, there has been a spectacular decline in the incidence of sexually transmitted diseases, particularly gonorrhoea and syphilis.

81. Chlamydia infection is by far the most common bacterial sexually transmitted disease in Europe. For some time its incidence had been seriously underestimated because of a lack of diagnostic facilities. In countries with an active chlamydia control policy, there has been a well-documented reduction in the number of cases, particularly in women.

82. Reliable data on the incidence of sexually transmitted diseases in developing countries are scarce, although prevalence surveys have been conducted in many countries, particularly in Africa. In general, the survey data show higher rates of gonorrhoea, syphilis and chlamydia than in comparable populations in Europe or Northern America. However, there is also a large variation in prevalence, with some populations having low levels of infection. It should be stressed that the prevalence rate of a bacterial sexually

transmitted disease is the result of both sexual exposure of the population and the proportion of infections adequately treated.

83. Women, especially young women, are more vulnerable than men to infection with a sexually transmitted disease and its complications (such as infertility, cancer and inflammatory diseases). The high prevalence of sexually transmitted diseases among women attending antenatal, family planning or gynaecological clinics in developing countries provides an indication of the extent of the problem of sexually transmitted diseases. For example, in studies in developing countries, up to 19 per cent of the pregnant women have been found to have gonorrhoea or chlamydia, up to 20 per cent to have syphilis.

84. Biologically women are more susceptible to most sexually transmitted diseases than men, at least in part because of the greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse. Women with a sexually transmitted disease are more likely than men to be asymptomatic, and, therefore, are less likely to seek treatment, resulting in chronic infections with more long-term complications and sequelae.

85. There are important overlaps between programmes for the prevention of HIV/AIDS and sexually transmitted diseases and care programmes and other components of reproductive health programmes. Family planning services and maternal health/antenatal care services offer an important opportunity for both diagnosis and treatment of sexually transmitted diseases, as well as information about their prevention, including safer sexual behaviour and related services such as the provision of condoms.

VII. REPRODUCTIVE RIGHTS

86. Reproductive health and rights are relatively new subjects in the area of population policy. Reproductive health and rights are also a particularly controversial topic. They relate to areas of life that are the most intimate and personal such as sexuality, sexual relations and reproduction, as well as to matters that are central to how the members of a family relate to one another and how they perceive themselves. They are also linked with the status of women and the empowerment of women, matters which, themselves, provoke controversy in many countries.

87. Reproductive rights may be viewed as certain rights that all persons possess that will allow them access to the full range of reproductive health care. In particular, as formulated at the past three international conferences on population and at the Fourth World Conference on Women, these rights include the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. They also include the right to attain the highest standard of sexual and reproductive health and the right to make reproductive decisions free from discrimination, violence and coercion. Furthermore, the Programme of Action of the International Conference on Population and Development and the Platform for Action of the Fourth World Conference on Women make clear that all of these rights are grounded in national laws, international human rights instruments and other international consensus documents.

88. Although the concept of reproductive rights is of relatively recent origin, there is ample support for those rights in existing international documents and human rights treaties. For example, the final documents adopted at all three international conferences on population as well as at the Fourth World Conference on Women strongly assert reproductive rights. Drawing on the language originally formulated at the International Conference on Human Rights held at Tehran in 1968, each document provides that all couples and individuals have the right to decide freely and responsibly the number and spacing of their children and the information, education and means to do so. While the documents are not legally binding in terms of international law, they do bear great normative authority and have been endorsed by the vast majority of Governments.

89. Formal international treaties that are legally binding also support the concept of reproductive rights, if not by name. For example, the International Covenant on Civil and Political Rights (the Political Covenant), contains a number of provisions that are relevant to the right to make voluntary decisions about bearing children. Similarly, the International Covenant on Economic, Social and Cultural Rights (the Economic Covenant) - the sister treaty to the Political Covenant - recognizes the right of persons to enjoy the highest standards of health and calls for special attention to be given to women before and after childbirth and to the reduction of infant mortality. With the approval of the Convention on the Elimination of All Forms of Discrimination against Women (the Women's Convention) in 1979, these reproductive rights are made explicit and strongly endorsed. National laws also support reproductive rights, with laws relating to maternal/child health care, access to the various forms of family planning, sex education and treatment and prevention of sexually transmitted diseases being common in both developing and developed countries.

90. One of the cornerstones of the concept of reproductive rights is the right of access to methods of family planning. This idea has been fundamental to definitions of reproductive rights from the beginning, appearing repeatedly in population and human rights documents as the right to have the "information and means" to decide freely and responsibly on the number and spacing of children. Without such access, reproductive rights have, practically speaking, no real meaning.

91. Adolescent reproductive behaviour has become an emerging world-wide concern. Most countries do not have coherent policies for the protection and maintenance of reproductive health in adolescents, partly because of the sensitivity of the subject. Several key issues concerning the reproductive rights of adolescents pertain to marriage. In many parts of the world, women's basic human rights are violated when they are given in marriage without their consent. Moreover, despite legislation designed to eliminate the practice, girls in many countries marry shortly after puberty and are expected to start having children almost immediately, in part because of a lack of alternative opportunities. The problems of early child-bearing are not only biomedical, but also result in reduced educational and economic opportunities for young mothers.

92. Many obstacles exist in the achievement of the goals of reproductive rights and reproductive health. Because of the sensitive and controversial character of the issues involved - in particular, sexuality, contraception, the empowerment of women and family relations - there is resistance to the expansion

of reproductive rights. Another major problem is conceptual in nature. In many countries, human and reproductive rights, as expressed in international documents, are not familiar to the general public and little information is disseminated on those rights. In addition, human and reproductive rights may seem abstract in their formulation or even foreign to local experiences, attitudes and traditions. The less educated are especially likely to lack knowledge about their rights. Also, women more than men are subject to restrictions on their personal status that prevent them from obtaining information on their rights. Thus, many women are not aware that they have reproductive rights; without such awareness they are unlikely to exercise those rights.

93. In the light of these obstacles, action to achieve reproductive rights and health is restricted in scope. One strategy to overcome such obstacles is to try to strengthen and make greater use of international treaty enforcement and monitoring mechanisms. Another strategy is to increase the provision of information and education on reproductive rights and reproductive health. Efforts can be increased to reach the millions of persons throughout the world who have little knowledge or understanding of reproductive health. These efforts can include furnishing basic facts on health and the reproductive system, as well as information on how reproductive health is closely connected to such matters as the age of marriage, education, the status of women and harmful practices such as female genital mutilation. Publicity can also be given to the existence at the international level of documents that countries have ratified which support rights in these matters, particularly the right to decide freely and responsibly on the number and spacing of children. Moreover, to be effective, provision of this information should be provided to medical personnel, religious leaders, government officials and non-governmental organizations.

94. Of critical importance is presenting the concept of reproductive rights in ways that are appropriate at the local level. One approach is to point to local laws that themselves support reproductive rights, such as the constitutions, population policies and health laws of various countries. Another is to draw on local social movements and traditions that support reproductive rights. A third approach is to relate "rights" language to the actual needs at the local level, needs for basic health services, family planning and education, for example. For the concepts of reproductive rights and reproductive health to be implemented at the local level, they need be integrated into existing social, political and religious structures and thus become part of the complex fabric of society.

VIII. POPULATION INFORMATION, EDUCATION AND COMMUNICATION

95. In the field of population, the term information, education and communication is used as the strategic combination of all three processes in efforts to provide information on services, create public awareness and advocate for action on population and development issues. The term information, education and communication programme interventions is usually conceived as an integral part of a country development programme, which aims at achieving

measurable behaviour and attitude changes of specific audiences, based on a study of their needs and perceptions.

96. The implementation of the Programme of Action of the International Conference on Population and Development requires political support and advocacy, understood here as a full commitment to its principles, goals and objectives. Effective advocacy is essential in creating awareness of reproductive rights and reproductive health and can be facilitated by the use of effective information, education and communication strategies. The importance of information, education and communication in the area of reproductive rights and reproductive health derives from the recognition that they are important instruments that stimulate attitudinal and behavioural changes. In the area of human reproduction and health, various strategies have been used in attempts to develop positive attitudes and encourage responsible and healthy behaviour, help increase community participation in population activities and facilitate acceptance of population programmes in diverse cultural settings.

97. A primary aim of information, education and communication activities should be to motivate policy makers, programme managers, service providers and communities to translate into action the concept of reproductive rights and reproductive health, including family planning. This will require the strengthening of national capacities to undertake appropriate information, education and communication activities. It will also require that information, education and communication messages be effective and that service-delivery systems respond to the increased demand that those messages contribute to generating.

98. There is a large variety of information, education and communication programmes that combine strategies of mass, group and one-to-one communication approaches and that use different channels, from interpersonal and peer support to formal school curricula, from traditional and folk media to mass entertainment and news media, and production and dissemination of specific materials. The spectrum of activities includes a large array of operations that covers awareness-raising campaigns, art exhibits, painting and poster competitions; design, development and distribution of information, education and communication and training materials; printing and distribution of booklets, brochures and comic books with family planning, sexual health and HIV/AIDS prevention messages; radio and television programmes, particularly soap operas with family planning and HIV/AIDS themes; dramas and puppet shows; seminars and workshops; telephone hot lines; and preventive counselling, including the distribution of condoms. When planned in a coordinated and strategic manner, these activities can make a significant contribution to the impact of population programmes.

99. Three key issues have been identified in population information, education and communication programmes. First, social, cultural and political conditions can affect the recognition of reproductive rights and may limit access to reproductive health services and information; myths and ignorance may constitute major obstacles. Secondly, information, education and communication activities are not always properly linked to the delivery of reproductive health and family planning information and services. And thirdly, there is a need for adequate indicators for measuring progress in this field.

100. Population policies and legislation have a major role to play in the creation of a supportive environment for reproductive health and family planning. Information, education and communication activities are facilitated when they are supported by population policies and appropriate legislation. It is also recognized that information, education and communication activities are valuable instruments for facilitating the understanding and acceptance of the goals and objectives of population policies.

101. Reproductive health and family planning programmes are usually a major component of national population policies and strategies, and information, education and communication activities provide strong programme support. Strengthening their links will make them mutually supportive and thus enable national programmes to better satisfy unmet demands through the delivery of high-quality reproductive health and family planning services. Many of these programmes include also the prevention and control of sexually transmitted diseases and HIV/AIDS and information, education and communication activities that are valuable tools in reaching groups at risk, especially adolescents, and in raising awareness and promoting behavioural change.

102. Population education is another common strategy adopted by Governments as part of their population policies. Population education programmes usually cover topics that range from population dynamics to pregnancy and family planning, family life, sex education and, more recently, new ways of looking at gender issues, and HIV/AIDS and sexually transmitted diseases. There is increasing evidence that sex and HIV/AIDS education programmes may reduce unsafe practices among sexually active adolescents and reduce early pregnancies.

103. The Programme of Action of the International Conference on Population and Development calls for a coordinated strategic approach to information, education and communication that should be linked to, and complement, national population and development policies and strategies and a full range of services in reproductive health, including family planning and sexual health (United Nations, 1995a, chap. I, resolution 1, annex, para. 11.19). Achieving such an objective requires that special attention be given to the following priority areas:

(a) Data requirements, indicators and future research. The development of appropriate mechanisms for collecting data and of instruments for assessing and evaluating programme effects should receive high priority. Assistance to country programmes for developing or strengthening their information systems for the management of information, education and communication programmes should be a priority;

(b) Adolescents. Because of the critical stage of their personal development, young people, particularly adolescents, have a special need for information on sexual and reproductive health, as well as on such other related issues as substance abuse and violence. Most young people are exposed to the mass media, classroom education and the influence of their family members, peers and the community at large and it is through these three principal channels that they gain the information, education and skills required to advance through the difficult passage to adulthood. The provision of information about sexuality, pregnancy and sexually transmitted diseases, combined with information about

local services and counselling availability, is an effective way of assisting young people. Their participation in such activities can help ensure that the messages are appropriate and compelling to their peers. They can also be involved in facilitating the community dialogue and debate that should be linked to those efforts. Youth organizations can also play a major role in health promotion for youth both in and out of school and contribute to making young people's immediate environment more supportive. Youth groups can make linkages with the health sector and help make health services more "youth-friendly". Such organizations can also play a role in involving parents and helping them understand and provide support to their adolescent children;

(c) Gender equality and equity. The Programme of Action affirms that the full participation and partnership of both women and men is required in reproductive life. Education and information that promote such aims, along with responsible sexuality and respect for women, are also fundamental to improving the status and role of women in society. Increasing the education given to girls and women contributes to their empowerment and to improved family health. Expanding women's knowledge of reproductive health and expanding their choices enables them to meet their reproductive goals. Information, education and communication activities can contribute to eradicating harmful practices against women and girls, such as female genital mutilation; drawing attention to the health needs of the girl child; eliminating nutrition practices that discriminate against girls; involving men in reproductive health and family planning programmes; removing barriers to women's rights and enforcing legislation on early marriage, sexual exploitation and violence; and in ensuring that women have equal access to education, are guaranteed equal opportunity to work and receive equal pay for equal work;

(d) Participation of programme users. Participation of programme users in the design, implementation and evaluation of information, education and communication programme interventions increases the likelihood of the success of those programmes. Various population groups have their own perspectives, ideas and opinions in many areas, particularly about sexual and reproductive health issues. Communicating effectively with them requires their direct participation;

(e) Training of personnel. Health professionals should be trained in basic information, education and communication matters to cater to the special needs of the populations they serve, including the areas of interpersonal communication, sexuality and counselling, as well as team building, that will promote work with social welfare workers, teachers, parents and community leaders. Training of educators and student peers to work with other students in educational and counselling activities should focus on techniques dealing with problem-solving, listening, non-judgmental communication, conflict resolution, decision-making, counselling and basic education, as well as sexual and reproductive health needs.

Notes

1/ Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (based on WHO, The Prevention and Management of Unsafe Abortion, Report of a Technical Working Group (Geneva), WHO/MSM/92.5). This definition was used in the Programme of Action of the International Conference on Population and Development, (Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex).

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FOLLOW-UP ACTIONS TO THE RECOMMENDATIONS OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT: REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

Monitoring of population programmes

Report of the Secretary-General

SUMMARY

The present report has been prepared in accordance with the new terms of reference of the Commission on Population and Development and its topic-oriented and prioritized multi-year work programme, which were endorsed by the Economic and Social Council in its resolution 1995/55. The topic for 1996 is reproductive rights and reproductive health.

This report, which reflects the responses received from representatives/country directors of the United Nations Population Fund (UNFPA) in 78 countries, is intended to give a broad overview of the range of activities that have been initiated in the aftermath of the International Conference on Population and Development in the areas of reproductive rights, reproductive health and population information, education and communication. It assesses the different strategies and approaches that countries have adopted to implement the recommendations in the Programme of Action of the International Conference on Population and Development concerning reproductive health and population information, education and communication. It also provides an analysis of the difficulties and constraints encountered by countries in implementing reproductive health and population information, education and communication programmes.

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INTRODUCTION

1. The present report on the monitoring of population programmes has been prepared in accordance with the new terms of reference of the Commission on Population and Development and its topic-oriented and prioritized multi-year work programme, which were endorsed by the Economic and Social Council in its resolution 1995/55. The theme for 1996 is reproductive rights and reproductive health, including population information, education and communication.

2. This report reviews progress with respect to population programmes and related development activities at the country level. It focuses on programme experiences in the area of reproductive rights and reproductive health and population information, education and communication. Since developed countries usually do not have explicit population policies, but rather separate clusters of policies, programmes and legislation, contrary to most developing countries which have, over the years, adopted comprehensive population policies and programmes, this report deals with the programme experiences of developing countries as well as countries with economies in transition. Since the principal focus of the report is the monitoring of population programmes, it primarily addresses operational activities in the area of reproductive health and related information, education and communication programmes and, to a lesser extent, reproductive rights.

3. In order to obtain the data and information necessary for the preparation of this report, the United Nations Population Fund (UNFPA) sent out a questionnaire to all its representatives and country directors in the field. The questionnaire was sent to 125 field representatives, covering more than 130 developing countries and countries with economies in transition. It contained questions pertaining to the main subjects covered in chapter VII. Reproductive rights and reproductive health, and chapter XI Population, development and education (part B) of the Programme of Action of the International Conference on Population and Development. 1/ More specifically, the questions referred to the following:

(a) Integration of family planning information and services into the broader framework of reproductive health;

(b) Quality-of-care aspects of reproductive health programmes;

(c) Dissemination of the Programme of Action of the International Conference on Population and Development and whether it was being translated into the national language;

(d) Existence of a national information, education and communication strategy for reproductive health;

(e) Reproductive health needs of adolescents;

(f) Extent of women's participation in the design and implementation of reproductive health programmes;

(g) Initiatives under way to increase men's participation in reproductive health programmes;

(h) Role of non-governmental organizations in the formulation and implementation of those programmes.

4. This report is based on responses received from 78 countries. 2/ The breakdown according to the regions from which the responses were received is as follows:

Region or group	Number of reports received
Sub-Saharan Africa (including Eastern, Middle, Southern and Western Africa)	33
Northern Africa and Western Asia	8
Asia (including Eastern, South-eastern and South-central Asia) and Oceania	17
Latin America and the Caribbean	17
Countries with economies in transition (including some countries in Eastern and Northern Europe)	3
Total	78

5. This report is intended to give a broad overview of the range of activities that have been initiated, since the International Conference on Population and Development was held, in the areas of reproductive rights, reproductive health and population information, education and communication. It is more qualitative than quantitative in its approach. The report assesses the different strategies and approaches that countries have adopted to implement the recommendations in the Programme of Action of the International Conference on Population and Development concerning reproductive health and population information, education and communication. It focuses on efforts to integrate family planning information and services into reproductive health programmes; quality-of-care aspects of those programmes; population information, education and communication programmes; and initiatives undertaken to address adolescent reproductive health needs and to increase women's participation, and strategies to involve men; as well as the role of the non-governmental sector. The report also analyses the difficulties and constraints encountered by countries in implementing reproductive health and population information, education and communication programmes.

I. INTEGRATION OF FAMILY PLANNING INTO REPRODUCTIVE HEALTH PROGRAMMES: CONCEPTUALIZATION AND OPERATIONALIZATION

6. Experiences over the past two decades have shown that family planning programmes work best when they are part of, or linked to, broader health-related initiatives that address closely related health needs. As a result of these experiences, there is an emphasis on reproductive rights and reproductive health in the Programme of Action of the International Conference on Population and Development and on the need to integrate family planning information and services into reproductive health programmes. The Programme of Action of the International Conference on Population and Development (para. 7.2) states:

> "Reproductive health ... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."

The Programme of Action of the International Conference on Population and Development further calls for information and services to be made accessible through the primary health-care system.

7. In 1995, following the International Conference on Population and Development, one of the first steps many countries took was to address the conceptualization and operationalization of the reproductive health approach in the particular context of their own country. Responding to the need for guidance, several United Nations bodies and organizations produced materials aimed at assisting countries in implementing reproductive health programmes. For example, the World Health Organization (WHO) issued several new publications on this topic. United Nations organizations and bodies also delineated their objectives and activities in operationalizing reproductive health. UNFPA revised its guidelines on reproductive health, the United Nations Children's Fund (UNICEF) presented its plans in this area to its Executive Board in 1995, and the World Bank issued a policy document on its role in improving reproductive health.

8. In an attempt to define the implications of the reproductive health approach for their national policies and programmes, 18 countries - Bhutan, Burkina Faso, the Comoros, Costa Rica, El Salvador, Ethiopia, India, the Islamic Republic of Iran, Jamaica, Malawi, Mali, Mongolia, Nicaragua, the Niger, Peru, Turkey, Viet Nam and Zambia - reported having organized workshops or seminars to discuss the implications of the reproductive health approach for their national population programmes. Workshops were held to familiarize planners and/or health-care workers concerning the new concept of reproductive health and its implications for programmes. In addition, medical associations in various countries organized forums or symposia to inform their members about the

reproductive health concept and approach and to discuss ways of conceptualizing and operationalizing the notion of reproductive health.

9. Countries took up the challenge of the Conference to adopt a reproductive health approach in many different ways. Of the countries responding to the survey, 50 (64 per cent of the respondents) reported having taken initial steps to broaden their existing family planning, maternal and child health (MCH), birth-spacing and/or safe motherhood programmes and to include in them other reproductive health information and services. In some countries in Africa, Governments are in the process of integrating reproductive health services into ongoing activities under the Bamako Initiative. This Initiative was set forth at a 1987 meeting of ministers of health of countries in sub-Saharan Africa to develop a strategy to revive, strengthen and extend basic health-care services.

10. In more than 30 countries, including 17 in sub-Saharan Africa, Governments reported having begun a process of reorientation and re-examination of existing policies. In Guinea, for example, the Ministry of Health initiated a review of the current modalities of its safe motherhood/family planning programme aimed at transforming it into a reproductive health/family planning (RH/FP) programme. In Indonesia, where the shift from family planning to reproductive health was initiated even before the Conference, the transition will be accelerated in its current five-year programme (1995-1999). This programme addresses such critical areas as quality of care in reproductive health services, the demand-fulfilment approach, prevention of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) within the framework of RH/FP through a family-centred approach, education of youth regarding reproductive health and family well-being, research and data collection on reproductive health and women, and promotion of women's empowerment. The Government of Paraguay decided to revise its national plan for reproductive health and family planning, elaborated just before the Conference, so as to adjust it to the new focus, principles and recommendations of the Programme of Action of the International Conference on Population and Development.

11. The Programme of Action of the International Conference on Population and Development (para. 7.9) calls upon Governments to promote community participation in reproductive health care by decentralizing the management of public health programmes. In several countries, Governments responded to this recommendation by taking steps towards decentralizing public health services to lower levels of administration. In Cameroon, for example, a programme aimed at strengthening and expanding RH/FP services within primary health-care programmes includes a component for the decentralization of RH/FP activities from the Ministry of Health to district and provincial levels.

12. The extent of integration of family planning into reproductive health programmes appears to depend largely on the state of health-care services and facilities. Countries in which most essential reproductive health services were already available to the majority of the population initiated activities directed towards previously unserved or underserved groups in society. Some of these countries focused instead, or in addition, on the introduction of more specific reproductive health services, such as the prevention and proper referral of infertility and the prevention and treatment of reproductive tract infections, as well as sexually transmitted diseases. In countries with less

well-developed health services, the full integration of family planning into reproductive health programmes was expected to take much more time. In many of these countries, Governments adopted an incremental approach to introduce reproductive health services gradually within the primary health-care system.

13. As stated in the Programme of Action of the International Conference on Population and Development (chap. VII) and reaffirmed in the Platform for Action, 3/ adopted at the Fourth World Conference on Women held in September 1995, reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and on the right to attain the highest standards of sexual and reproductive health. Reproductive rights also include the right to make decisions concerning reproduction free of discrimination, coercion and violence (para. 7.3). The two main aspects of reproductive rights involve information and services. As described above, in most of the countries responding to the inquiry, initiatives were under way to increase the scope of reproductive health services. The initial steps taken by Governments to create awareness of reproductive health are discussed below.

14. Some countries framed the assurance of reproductive rights within a larger approach to issues of reproductive health, population and sustainable development. For example, the Government of Bolivia issued a Declaration of Principles on Population and Sustainable Development, which states that "one crucial aspect of MCH is reproductive health, and a key component of this reproductive health is family planning, undertaken as the fundamental right of couples and individuals to decide freely and responsibly the number of their children and the spacing between them".

II. QUALITY-OF-CARE ASPECTS OF REPRODUCTIVE HEALTH PROGRAMMES

15. The emphasis on a comprehensive reproductive health approach in population programmes has led to increased attention to the quality of care provided to clients. The Programme of Action of the International Conference on Population and Development stresses the need to improve the quality of care of reproductive health and family planning programmes as an effective way to address existing unmet demands for reproductive health information and services (see the Programme of Action, para. 7.23 (a)-(h)). Of the countries responding to the inquiry, 52 reported having initiated activities to improve the quality of care provided: 24 from sub-Saharan Africa, 4 from Northern Africa and the Middle East, 13 from Asia and Oceania, 10 from Latin America and the Caribbean, and 1 from countries with economies in transition.

16. Most of these countries were pursuing the following similar paths to increase or improve the quality of reproductive health services: (a) developing human resources, including training of medical and/or paramedical staff in reproductive health; (b) improving infrastructure; (c) developing medical protocols for RH/FP services; and (d) increasing the availability of reproductive health services.

A. Human resource development, including training

17. The training of health-care providers - doctors, nurses and midwives - in reproductive health and family planning matters and/or the review and revision of training materials seem to be standard components of most of the reproductive health-care projects developed in the countries responding after the Conference was held. An often-cited objective of training programmes is to increase the number of service providers so as to expand service coverage, particularly in rural areas. Through such training, service providers and health-care planners and supervisors are made aware of the latest developments with regard to reproductive health issues, of the need for clients to have the opportunity to make informed choices, and of the need for honest and compassionate counselling of clients on reproductive and sexual health matters.

18. The Philippines reported, for example, having trained about 80 per cent of all governmental and non-governmental health workers in basic and comprehensive family planning and interpersonal communication skills. Viet Nam reported that its programme included the review and revision of training curricula and materials based on findings from the assessment of quality of care of family planning services in Viet Nam, the Rapid Evaluation Method (REM) survey, and job descriptions and task analyses of the MCH/FP health personnel. The Comoros reported that the manual for health-care providers was being elaborated to include information, education and communication aspects, the importance of client confidentiality and the need for mechanisms for follow-up of contraceptive users. The last-mentioned measure is in line with the recommendation in the Programme of Action of the International Conference on Population and Development (para. 7.23), which states: "In the coming years, all family-planning programmes must make significant efforts to improve quality of care. Among other measures, programmes should: ... (e) ensure appropriate follow-up care, including treatment for side-effects of contraceptive use".

B. Infrastructure

19. The increased attention to quality-of-care aspects of reproductive health programmes appears to have led to increased concern for the health-system infrastructure, particularly in terms of the maintenance of health-care facilities and the availability of sufficient supplies of medical equipment and drugs, including contraceptives. Of the countries responding, 20 - Benin, Burkina Faso, Cambodia, Cameroon, Cape Verde, Côte d'Ivoire, Ecuador, the Gambia, Guinea-Bissau, Guinea, the Lao People's Democratic Republic, Mexico, Myanmar, Namibia, Nicaragua, the Niger, Senegal, Sierra Leone, the United Republic of Tanzania and Zimbabwe - reported having undertaken initiatives aimed at improving the health-care infrastructure and facilities. In Côte d'Ivoire, for example, beginning in 1993, health-care centres had been renovated and equipped: 20 of those centres were already operational and another 20 were expected to have been renovated and equipped by the end of 1995. Similarly, in Nicaragua, the Ministry of Health was working, in cooperation with non-governmental organizations, on improving the infrastructure and equipping primary health-care units. In Cambodia, the Government was addressing the quality of care through, inter alia, the repair and rehabilitation of health-care facilities and the provision of medical equipment.

20. The Programme of Action of the International Conference on Population and Development (para. 7.23 (a)) recommends that family planning programmes "recognize that appropriate methods for couples and individuals vary according to their age, parity, family-size preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective family planning methods in order to enable them to exercise free and informed choice". Governments, often with the assistance of the international donor community, began to respond to the need to expand the availability of different contraceptive methods by increasing the method mix in health-care facilities. Projects have been formulated to introduce previously unavailable methods, while at the same time strengthening the general supply of contraceptives.

21. Some countries reviewed their organizational infrastructure with the aim of assessing effectiveness and efficiency. The Ministry of Health in Peru, for instance, undertook an organizational restructuring to facilitate the integration of MCH, adolescent health, cancer detection and family planning programmes within the Social Programmes Directorate of the Ministry of Health; doing so allowed the Ministry to streamline its health policies and fostered a more integrated approach to reproductive health. The Government of Mexico, in December 1994, merged its Directorate-General of Family Planning and Directorate-General of Maternal and Child Health within the Ministry of Health into one Directorate-General of Reproductive Health, in an organizational change intended to strengthen both components.

22. To be able to meet the increased demands for contraceptives, 13 of the countries responding to the inquiry - Bangladesh, Burundi, Ecuador, Ethiopia, the Lao People's Democratic Republic, Namibia, Nicaragua, Panama, Togo, Uganda, the United Republic of Tanzania, Viet Nam and Zambia - reported having programmes formulated since the Conference to pay special attention to the need to improve the national logistics management information systems (LMIS), which enable countries to respond to declining stocks. The Government of Ecuador, for instance, initiated a project to strengthen the LMIS of its national family planning programme. In the United Republic of Tanzania, a nationwide LMIS has been established to improve storage, ordering and forecasting of family planning and AIDS-prevention methods. All MCH coordinators and AIDS-prevention coordinators were being trained in LMIS. This training has led to improvements in storage, ordering and forecasting of commodities. In Viet Nam, following the Conference, the Government included the strengthening of its logistics system, covering the distribution of contraceptives, as well as the FP/MCH management information system (MIS), in the current programme cycle.

C. Medical protocols

23. In a number of countries responding to the inquiry, initiatives were under way to revise or update medical standards for RH/FP or related programmes. For example, the Ministry of Health of Ghana developed safe motherhood clinical protocols aimed at standardizing service delivery, as well as reorienting and enhancing the training of service providers. The major components of this protocol include family planning, prenatal and postnatal services, supervised delivery, the management of complications as a result of abortions, and the

prevention and treatment of sexually transmitted diseases and HIV/AIDS. In 1994, the Government of Côte d'Ivoire adopted a national family planning policy, which sets the standards for health professionals in providing family planning information and services in the context of maternal and child health.

24. In Pakistan, the Government published and disseminated to health-care providers a Manual of National Standards for the Delivery of Family Planning Services, which covers all contraceptive methods. In Egypt, the Government undertook several initiatives to improve the quality of RH/FP services. One of them was the review and updating of the National Clinical Guidelines to include the latest developments in reproductive health and family planning. In Nepal, quality-assurance teams undertake regular field visits to ensure that standards are being met.

D. Availability of reproductive health services

25. Although efforts are under way to improve the quality of reproductive health and related services, in the majority of developing countries responding to the inquiry, the full range of reproductive health services were either unavailable or inadequately available to all eligible women and men. Table 1 shows the number of countries offering selected components of reproductive health by degree of availability.

26. It is clear from table 1 that, of the various reproductive health components, the most widely available were family planning counselling, information, education and communication services, and facilities for prenatal care, safe delivery and postnatal care. In one fourth of the countries responding to the inquiry, however, family planning information and services were considered inadequately available to all women and men. Several reports mentioned that in most cases, most, if not all, components of the reproductive-health approach were available for middle- and higher-income groups in urban areas, whereas those services were not available or inadequately available to the majority of the urban and rural poor.

27. Of the 78 countries responding, 10 (13 per cent) reported having all seven components of reproductive health programmes, as described in table 1, available to all women and men through the primary health-care or other health-related system. Thus, in the majority of countries responding, the full range of reproductive health-care services was either not yet available or inadequately available.

Table 1. Availability of reproductive health components

Reproductive health component	Available		Inadequately available		Not available		Not ascertained	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Family planning counselling, information, education and communications services	49	63	19	24	3	4	7	9
Education and services for prenatal care, safe delivery and postnatal care, especially breast-feeding and infant and women's health care	55	71	11	14	5	6	7	9
Prevention and appropriate treatment of infertility	30	38	18	23	23	30	7	9
Abortion, as specified in para. 8.25 of the Programme of Action of the International Conference on Population and Development including prevention of abortion and management of the consequences of abortion	25	32	16	21	30	38	7	9
Treatment of reproductive tract infections	30	38	17	22	24	31	7	9
Sexually transmitted diseases and other reproductive health conditions, including cancers of the reproductive system	38	49	19	24	14	18	7	9
Information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood	35	45	15	19	21	27	7	9

Source: UNFPA inquiry, 1995.

Note: The subheading "number" refers to number of countries offering a given component by degree of availability; the corresponding subheading "percentage" refers to the number as a percentage of the total number of countries (78) responding to the inquiry.

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III. POPULATION INFORMATION, EDUCATION AND COMMUNICATION

28. Any new concept needs to be accompanied by an information, education and communication (IEC) strategy to make people aware of its content and implications - all the more so if this new concept involves, as does the concept of reproductive rights and reproductive health, many aspects, ranging from sociocultural factors - cultural beliefs and practices, status of women, overall health and well-being, religious convictions and ethical values - to economic conditions.

29. Of the 78 countries responding to the inquiry, 25 (32 per cent) reported having a national IEC strategy for reproductive health (see table 2). In most cases, these national strategies were closely linked with service delivery. Of the respondents, 16 countries (21 per cent) reported that efforts were under way to develop a national IEC strategy for reproductive health. Thus, a little more than 50 per cent of the countries from which information was received will soon have a national IEC strategy focusing on reproductive health and related subjects. More than 50 per cent of the countries in sub-Saharan Africa (18 out of 33 countries) for which information was available had, or were in the process of developing, a national IEC strategy. In Northern Africa and Western Asia, 4 out of 8 countries had formulated, or were in the process of formulating, and national policy. In Asia and Oceania, 10 out of 17 countries had, or were in the process of developing, a national IEC strategy. In Latin America and the Caribbean, 8 out of 17 countries had, or were in the process of formulating, a national IEC policy. In countries with economies in transition, 1 country out of 3 had done so.

30. The absence of a national IEC policy for reproductive health, does not necessarily mean, however, that no initiatives were under way in those countries. In nearly all countries from which information was received, IEC activities were being carried out aimed at increasing awareness of reproductive health and family planning. Those activities were often part of larger RH/FP or related programmes, using a variety of communication channels (such as print media, radio and television), interpersonal communication and traditional communication techniques (such as drama, songs, dances and the use of puppets, posters and leaflets).

31. In some countries, it was felt that IEC activities were not yet adequately linked with service delivery, and that this thereby limited the impact of IEC programmes on RH/FP behaviour. Other obstacles were also observed in a number of countries, such as a prevalence of high illiteracy; the notion that reproductive health matters were private and should therefore not be discussed in public; lack of IEC materials; limited IEC skills of health providers; cultural and traditional beliefs and values preventing, for instance, awareness creation among youth; and lack of an effective non-governmental sector, which hampered the implementation of IEC activities and their intended impact.

32. The international community considers generating greater public awareness, understanding and commitment to be vital for the successful implementation of reproductive health programmes. The Programme of Action of the International Conference on Population and Development therefore calls on all parties concerned to strengthen existing IEC activities. The first step after the

Table 2. Countries with a national information, education and communication (IEC) strategy, by region or group

Region or group	Number of countries responding	Number of countries having national IEC strategy	Number of countries developing IEC strategy
Sub-Saharan Africa (including Eastern, Middle, Southern and Western Africa)	33	11	7
Northern Africa and Western Asia	8	2	2
Asia (including Eastern, South-eastern and Western Asia) and Oceania	17	6	4
Latin America and the Caribbean	17	5	3
Countries with economies in transition (including some countries in Eastern and Northern Europe)	3	1	0
Total	78	25	16

Source: UNFPA inquiry, 1995.

Conference would have been to give wide dissemination to the Programme of Action of the International Conference on Population and Development. From information obtained from responses to the inquiry, it is clear that the Programme of Action of the International Conference on Population and Development has been widely disseminated (75 out of 78 countries responding). In most cases, both Governments and UNFPA field offices were responsible for the dissemination of the document. Copies were sent to ministries, project staff, the media, non-governmental organizations, universities and other interested organizations and individuals. Seminars, workshops and media briefings were held in many countries to spread news on the Conference and its implications. In almost all the 78 countries that responded to the inquiry, newspapers, radio and television programmes reported on the Conference.

33. In terms of translation of the Programme of Action of the International Conference on Population and Development into national languages, the picture is quite different. In less than 50 per cent of the countries responding (38 out of 78 countries) was the Programme of Action of the International Conference on Population and Development translated into the national language, and the figure's being even this high was owing partly to the fact that the national language happened to be one of the six official languages of the United Nations

(Arabic, Chinese, English, French, Russian and Spanish) in which the document had been published. In most countries in sub-Saharan Africa and Asia and Oceania, apart from those countries where Arabic, English or French is the official national language, the document has not yet been translated into the national language. In some countries, however, translation activities are under way. Many countries in Africa have several official national languages; thus, it has been reported that translation into all of those languages seems to be almost impossible to achieve in a short time. As of this writing, the Programme of Action of the International Conference on Population and Development has been translated into Amharic, Bahasa Indonesia, Farsi, Mongolian and Vietnamese.

IV. FOCUS ON SPECIFIC GROUPS

34. The Programme of Action of the International Conference on Population and Development recognized that certain groups, including adolescents, women and men, are in need of special attention as specific audiences for reproductive health information and services.

A. Adolescents

35. The Programme of Action of the International Conference on Population and Development encourages Governments to address adolescent sexual and reproductive health issues through, inter alia, the provision of appropriate services and counselling (see the Programme of Action of the International Conference on Population and Development, para. 7.44 (a)). From the responses received, it seems that, in many countries, the International Conference on Population and Development clearly triggered a process aimed at giving far greater attention than ever before to the needs and problems of adolescents in the field of sexual and reproductive health. Nearly two thirds of the countries responding to the questionnaire reported having undertaken initiatives to address adolescents' reproductive rights and reproductive health and to put their needs in the political agenda. In some cases, these initiatives were undertaken by Governments; in others, in cooperation with, or solely by, non-governmental organizations.

36. Many Governments are taking various steps to address the special needs of adolescents. The Government of Cambodia, for example, issued guidelines for service providers on taking special care of adolescents and unmarried clients and not discouraging them from coming to service delivery points. In Ghana, the Government established a National Steering Committee on Adolescent Reproductive Health, aimed at strengthening coordination and providing a forum for planning and executing activities of the Committee in the country. In Côte d'Ivoire, special plays directed at youth and adolescents were being written and performed. In Uganda, a participatory process was set in motion which resulted in the formation of the Programme for Enhancing Adolescent Reproductive Life. The Programme aims at enhancing the reproductive health of Ugandan adolescents through the provision of appropriate counselling and services. To ensure sustainability, the Programme calls for young people and community leaders to take a leading role in implementation efforts.

37. Often, Governments and non-governmental organizations were working hand in hand to address adolescent reproductive health issues. In Mexico, even before the International Conference on Population and Development, a national-level meeting attended by governmental and non-governmental organization representatives issued the Declaration of Monterrey, which recognizes the needs and demands of adolescents. At the time of the UNFPA inquiry, there were 78 reproductive health-care units for adolescents installed in health-care facilities throughout the country, where information and advice were given and where reproductive health services and family planning were promoted. By the end of November 1995, it was expected that the entire country would be covered by the adolescent-care programme and that each state would have a minimum of two units, one in an urban health centre and another in a general hospital. A similar form of cooperation between government and non-governmental organizations took place in Morocco, where the Ministry of Youth and Sports and the Moroccan Family Planning Association developed an innovative approach to young people's needs. Five regions of Morocco were being covered by a programme to educate youth about reproductive and sexual health through the so-called youth clubs. In those clubs, adolescents create their own materials such as songs, drama and puppet shows, the best of which are shown at national festivals. The projects cover such topics as family planning, sexually transmitted diseases and HIV/AIDS, communication and family life, and sex education.

38. In countries where adolescent reproductive health issues were not being addressed by governmental or other programmes for a variety of reasons, religious and/or cultural factors were most frequently mentioned as reasons for not addressing the reproductive health needs of this age group. The responses to the inquiry revealed that in many countries where Governments were reluctant to address adolescent sexuality and reproductive health needs of adolescents, non-governmental organizations were filling the gap and undertaking activities for adolescents. Often, non-governmental organizations and other local or community-based organizations were in a unique position to work in this area. In line with aspects of the recommendation contained in the Programme of Action of the International Conference on Population and Development (para. 7.48), many non-governmental organizations were training peer groups in counselling techniques to provide guidance to adolescents in matters related to responsible sexual and reproductive behaviour.

B. Women's participation

39. A crucial aspect for the introduction of a reproductive health approach in any country is the level of women's participation in decision-making processes. Paragraph 7.7 of the Programme of Action of the International Conference on Population and Development states, inter alia, that:

> "Reproductive health-care programmes ... must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services. Governments and other organizations should take positive steps to include women at all levels of the health-care system."

From that perspective, it might be useful to see whether the level of women's effective participation in the design and implementation of reproductive health programmes changed after the Conference.

40. The information received indicates that the level of participation differed considerably from country to country. A total of 41 countries reported having women in decision-making positions in the health-care system. The information received does not permit quantification of the proportion of the positions held by women, nor does it permit the delineation of trends. However, examples were given of women's decision-making roles and impact. In El Salvador, for instance, it was reported that women in decision-making positions in the health-care system and in the National Assembly were speaking out on issues related to women's health and well-being. It was reported that the Government of Togo recently changed the organizational structure of the Family Health Division in its Ministry of Health, with women occupying 8 of the 17 decision-making positions, inter alia, as heads of the Departments of Information, Education and Communication, Safe Motherhood, and Child Nutrition, the National Contraceptive Depot and Supervision of RH/FP in the Lomé district.

41. Information gathered from the responses received illustrates that the health sector is quite vulnerable to economic and social crisis. Since women make up most of the workforce in this sector, women's participation in health care in general, and reproductive health care in particular, is often hardest hit in times of economic hardship.

42. Based on the responses received, it would appear that gender concerns are increasingly being taken into account in programme design and implementation. In many reproductive health programmes, gender issues are already included. For example, the Government of Mexico set aside a special unit within the Directorate-General of Reproductive Health to advise on the inclusion of gender in the programme. In a large number of countries, gender training has become a standard component in many projects. Also, female consultants are being used for project formulation, implementation, monitoring and evaluation. In Costa Rica, for example, more than half of the reproductive health projects that were being implemented or prepared had women consultants and decision makers actively participating in project formulation and implementation.

43. One of the more visible signs of women's involvement in the planning, formulation and implementation of reproductive health programmes is through the rapidly growing number of non-governmental organizations dealing with reproductive health care. Often, these non-governmental organizations are headed by women, and the majority, if not all, of their staff are women. As a result of the Conference, Governments have become increasingly inclined to collaborate with national and/or local non-governmental organizations and other grass-roots or community-based organizations. Thus, given the growing importance of those organizations in project execution, the role of women in decision-making should steadily increase in the coming years.

C. Role of men

44. In many of the 78 countries responding to the inquiry, there seems to be awareness of the need to integrate men into all aspects of reproductive health programmes. Of the countries responding, 36 (46 per cent) reported having started programmes specifically directed at male involvement in reproductive health programmes (see table 3).

Table 3. Special programmes to increase male involvement in reproductive health, by region or group

Region or group	Number of countries responding	Number of countries with special programmes
Sub-Saharan Africa	33	20
Northern Africa and Western Asia	8	2
Asia and Oceania	17	9
Latin America and the Caribbean	17	4
Countries with economies in transition	3	1
Total	78	36

Source: UNFPA inquiry, 1995.

45. In some countries, this has resulted in innovative interventions aimed at reaching out to men so as to involve them in issues related to reproductive and sexual health, family planning and their responsibility in these areas. In Côte d'Ivoire, for example, male nurses were being trained in order to reduce the barriers against men's making use of health-care facilities. In addition, an IEC project was backing the reproductive health programme by producing flip charts addressing male heads of families. Similar programmes were being implemented in other countries. In the Philippines, male peer counsellors were being trained to convince married men to practise or support family planning. This approach had been adopted in response to the finding that many women refused to practise family planning, not because they themselves did not want to but because their husbands prevented them from doing so. A similar approach was being followed in a number of other countries as well. Another innovative approach being implemented in the Philippines was the establishment of the first male reproductive health centre, catering to the specific (reproductive) health needs of men. In Sierra Leone, a non-governmental organization was running a similar exclusively male clinic.

46. In other countries, plays were developed specifically for men as a way to stimulate discussion among them on the use of family planning and their responsibility in this area. In Ghana, for example, a series of community-based seminars and drama performances had been organized for both male and female audiences to educate and counsel them on issues concerning population and reproductive health.

47. Another initiative in reaching out to men was under way in Nepal. In order to increase male participation in reproductive health and family planning, condom boxes were being placed in almost all the health facilities of the country, thereby providing free and unhindered access to condoms by all. In Peru, vasectomy was officially approved by the Government as a method of family planning. The Government of Indonesia recognized the need to develop and expand the current counselling programme to include and improve the existing training programmes and to develop training materials that focused on male participation in family planning.

V. ROLE OF NON-GOVERNMENTAL ORGANIZATIONS

48. The Programme of Action of the International Conference on Population and Development (para. 7.9) calls for a broad and effective partnership between Governments and the non-governmental sector in delivering reproductive health information and services. Governments are encouraged to promote much greater community participation in reproductive health-care services by decentralizing the management of public-health programmes and by forming partnerships in cooperation with local non-governmental organizations and private health-care providers. The inquiry attempted to ascertain whether, one year after and as a result of the Conference in Cairo, the role of non-governmental organizations in the development, implementation, monitoring and evaluation of national reproductive health programmes had increased.

49. From the information received from 78 countries, it is clear that the involvement of non-governmental organizations differed greatly from country to country. The trend seemed to be towards more involvement of those organizations, even in those countries where they had been practically non-existent before the Conference. In several countries, international non-governmental organizations were also working in the field of reproductive health, thereby complementing or supplementing services provided by government facilities and/or through national non-governmental organizations.

50. In many of the countries responding to the inquiry, non-governmental organizations provided and continue to provide a large volume of reproductive health services, and information and education, thereby increasing both the demand for and the access to those services. The Togolese Family Welfare Association was operating a model clinic to demonstrate the integrated approach to reproductive health and family planning services, through service delivery, training and research, and it planned to establish regional model clinics in four more districts of the country. In Maldives, the first family planning clinic in the country was established by a national non-governmental organization in January 1995.

51. From the information received, it appeared that non-governmental organizations had become effective partners for Governments through their involvement in follow-up mechanisms, such as national committees or councils, set up in several countries to coordinate the national implementation of the Programme of Action of the International Conference on Population and Development. At the same time, non-governmental organizations had also been increasingly collaborating and networking in order to expand their influence in project formulation and execution. One example was in Ethiopia, where 11 non-governmental organizations had established a Consortium of Non-Governmental Organizations in Family Planning.

52. Traditionally, non-governmental organizations have played an important role by providing information and services to those segments of society not addressed by official governmental programmes, such as the poor, adolescents, commercial sex workers, unmarried couples and men, or by focusing on sensitive or controversial issues, such as traditional harmful practices against women, violence against women and abortion. The non-governmental sector has often been a front runner in innovative approaches to issues related to women's health, reproduction and family planning.

53. In times of dwindling public resources for investments in the social sector, including the health sector, the role of the non-governmental and private sectors becomes more important. However, some countries reported that the increased demands placed on non-governmental organizations to be full partners in the implementation of reproductive health programmes have led to an overburdening of those organizations. Also, some countries reported that, as a result of worsening economic conditions, the services provided by non-governmental organizations had been negatively affected. In other countries, the non-governmental organizations had been unable, owing to financial constraints, to reach large segments of society, particularly in the rural areas. In addition, financial difficulties had led some non-governmental organizations to shift their focus from low- to middle-income target groups.

54. Based on the responses received, there is reason to believe that the Conference has influenced the work of non-governmental organizations. As a result of the emphasis placed by the Conference on a holistic and comprehensive approach to reproductive health, traditional family planning-type non-governmental organizations are increasingly broadening their services to include other reproductive health services in their clinics, and their staff are being trained with respect to the implications of this new concept of reproductive health.

VI. PROGRAMMING IN REPRODUCTIVE HEALTH: CHALLENGES AND CONSTRAINTS

55. While a number of impressive initiatives are under way, responses to the inquiry show that many countries still face formidable obstacles or challenges which need to be addressed so that those countries can fully implement the recommendations in the Programme of Action of the International Conference on Population and Development in the area of reproductive health. In general, these obstacles can be classified using three categories: (a) sociocultural

factors; (b) infrastructure and accessibility; and (c) economic and financial aspects.

56. As is shown in table 4, sociocultural factors, such as lack of awareness among the public as well as among health professionals and planners, and cultural and traditional values, were the most frequently mentioned constraints with respect to implementing reproductive health programmes. Infrastructural constraints, such as poor coordination between ministries, the complexity of health-system structures, and the quality and skills of health professionals, were also often reported as constituting important obstacles to appropriate implementation of reproductive health programmes. Limited financial resources for the health sector was also cited in a large number of reports as a factor affecting those programmes.

Table 4. Principal constraints faced in implementing reproductive health programmes, by region or group

Region or group	Number of countries responding	Constraints		
		Sociocultural factors	Infrastructure and accessibility	Economic and financial aspects
Sub-Saharan Africa a/	33	29	26	21
Northern Africa and Western Asia	8	4	4	3
Asia and Oceania b/	17	13	17	8
Latin America and the Caribbean	17	12	10	6
Countries with economies in transition c/	3	2	0	1
Total	78	60	57	39
Total as percentage of total number of countries responding	100	77	73	50

Source: UNFPA inquiry, 1995.

a/ Including Eastern, Middle, Southern and Western Africa.

b/ Including Eastern, South-eastern and South-central Asia.

c/ Including some countries in Eastern and Northern Europe.

A. Sociocultural factors

57. Low levels of education often contribute to low awareness as regards reproductive health. Illiteracy and the low status of women were frequently mentioned as inhibiting factors in raising awareness with respect to the reproductive health concept. Also, based on information received, there is reason to believe that not only institutions and organizations find it difficult to react promptly and adequately to changes in health approaches but the public as well, in part because of the frequency with which new terms and health concepts are introduced.

58. Cultural factors can have a profound impact on the availability of reproductive health information and services. Pronatalist sentiments in parts of the world have impeded or limited concerted and decisive actions by Governments to increase the availability of such information and services since the Conference. Male attitudes and men's opposition to reproductive health and family planning constituted another factor in limiting service delivery in this area. Male opposition, often in combination with religious objections, was frequently given as a reason for the reluctance of Governments to plan interventions. Formal opposition or outright resistance from the religious hierarchy or establishment was a powerful factor in a number of countries. This resistance to reproductive health sometimes stems from misconceptions about the actual meaning of the concept or from misrepresentations of religious positions regarding different dimensions of population. Finally, the absence of female physicians, particularly in rural areas, has caused women to refrain from seeking reproductive health information and services in several developing countries.

B. Infrastructure and accessibility

59. In many of the countries responding to the inquiry, Governments faced structural obstacles or difficulties which hampered their ability to implement reproductive health programmes. Because the reproductive health concept requires a holistic and comprehensive approach, cooperation and collaboration among sectoral ministries are a necessity. Lack of coordination among the responsible ministries was one of the most frequently cited obstacles to the creation and implementation of a comprehensive reproductive health policy. Donor coordination was reportedly limited or weak in several countries, and in many, Government decision-making was still highly centralized. This often inhibited the involvement of government officials at lower levels, such as those at regional or district levels, as well as the involvement of the non-governmental sector.

60. Sometimes, the structure of a responsible ministry, often a ministry of health, is not conducive to effective management and coordination of national reproductive health programmes. In many ministries of health, management information systems are weak or are not functioning adequately, and this leads to poor logistics and data collection and analysis. The organization of the health system may itself become an obstacle to the implementation of reproductive health programmes. The existence of several vertical health programmes (for instance, MCH, primary health care, HIV/AIDS prevention), each

with its own institutional compartments within health ministries, can impede the integration of reproductive health services.

61. The limited coverage of health facilities, particularly in rural areas, poor referral or inadequate service delivery systems and the lack of human resources play further major roles in terms of limited access to reproductive health services and the quality of care provided in those facilities. In addition, the low level of staff motivation, frequent replacements and/or the mobility of health personnel and lack of technical skills were frequently cited as barriers to the implementation of a comprehensive reproductive health approach.

62. Some reports mentioned discrimination against women or youth as a factor limiting their ability to participate in reproductive health care. Sometimes, health-care providers were reluctant to address women's or adolescents' (reproductive) health needs. Also, the reportedly improper treatment of clients in health facilities in a number of countries demonstrates the lack of respect for women's needs and perspectives. The respectful treatment of clients in health facilities is regarded as an important element of high quality of care. Lack of such treatment reduces people's willingness to use the available services.

63. The geographical situation of some of the developing countries responding to the inquiry places an additional burden on their ability to provide reproductive health services, particularly to the more remote areas. Island States, such as the Philippines, along with countries covering vast areas of land, such as Namibia, and mountainous countries, such as Nepal, reported lacking the infrastructure to cover their entire territory.

C. Economic and financial aspects

64. Insufficient domestic financial resources to provide for adequate reproductive health services were frequently mentioned as affecting Governments' abilities to intervene in the health sector in general, and in reproductive health in particular. In several countries, economic hardship prevented Governments from allocating the necessary resources for reproductive health programmes. This, in turn, had detrimental effects on the provision of and access to services, most visibly in shortages of staff, supplies and other materials needed in health facilities and poor accessibility of services due to limited coverage of health services throughout the country concerned.

65. The lack of domestic resources is, in several countries, further affected by the allocation of large proportions of the Government's budget for the health sector to spending on salaries. As much as 80 per cent of the health budget may be spent on staff salaries, leaving 20 per cent for programme-related activities. Many developing countries remain to a large extent donor-dependent and therefore vulnerable to changes in donor policies or priorities, as well as to the political, social and economic situation in donor countries.

66. Other economic obstacles, in particular poverty and its manifestation at the household level, have inhibited access to reproductive health services.

Poverty has a profound impact on people's ability to receive reproductive health information and services. Poverty not only hampers people's (financially related) access to such information and services but also limits their access to education, thereby contributing to a low awareness of the reproductive health concept in many developing countries.

VII. CONCLUSIONS

67. This report has reviewed the implementation of population programmes in the field of reproductive rights and reproductive health one year after the International Conference on Population and Development and the adoption of the Programme of Action of the International Conference on Population and Development. The information received revealed that many Governments of developing countries and countries with economies in transition had taken significant steps in responding to the call for action in this area by the Programme of Action of the International Conference on Population and Development. In almost two thirds of the countries responding to the inquiry, initiatives are under way to broaden family planning information and services to include other reproductive health elements in their programmes.

68. The Conference has already helped crystallize issues and acted as a catalyst. Subjects previously ignored or simply overlooked have come to the fore as a direct result of the Conference and the Programme of Action of the International Conference on Population and Development. For instance, the needs and perspectives of adolescents are apparently receiving markedly increased attention. Nevertheless, those needs remain a sensitive issue in many countries. Non-governmental and youth organizations are apparently filling the gap left by Governments of countries where adolescent reproductive health is still a controversial issue.

69. Another issue that many countries now recognize as being important for an effective implementation of reproductive health programmes is the role and responsibility of men in matters related to sexuality, family planning, parenting, family life and gender equality. As mentioned earlier, numerous initiatives are under way to involve men in existing programmes or to formulate special programmes for them. It is too early to assess the successes of those programmes, but the increased attention to this issue attests to the serious commitment that many Governments have made to the implementation of the recommendations of the Conference. The fact that negative male attitudes towards reproductive health and related issues, as indicated in many country reports, still exist and are often difficult to overcome justifies even more the need to address male involvement in this matter.

70. A third subject that is increasingly being addressed is the issue of quality of care in RH/FP programmes. Countries have begun taking steps to improve or measure the quality of care provided to clients and have been paying increased attention to the physical state of health-care facilities. In a large number of countries, health-care providers are being trained in client-oriented service delivery and the importance of confidentiality. Governments are also more responsive to expanding the availability of a variety of contraceptives so as to address the different contraceptive needs of clients.

71. The non-governmental sector is playing an important role in the implementation of reproductive health programmes. Governments seem to be more convinced of the potential and competence of community-based organizations in supplementing or complementing their own efforts in reaching unserved or underserved population. In addition, the Conference itself also had a positive impact on the non-governmental sector, with non-governmental organizations redefining their own role, policies and programmes. The increased demand on the non-governmental sector may lead to overburdening of non-governmental organizations. In many countries responding to the inquiry, national non-governmental organizations were still weak in terms of resources, skills and experience of their staff, and expertise, and their ability to be involved in national execution of reproductive health programmes was hampered thereby. In some countries, Governments have already experienced the limitations of non-governmental organizations. There is a general need for a critical assessment of the potential of national non-governmental organizations to be partners in development in general and reproductive health in particular.

72. Despite encouraging signs of commitment and dedication to the implementation or strengthening of reproductive health programmes, the socio-economic and cultural environment is not always conducive to change. On a national level, widespread poverty severely hampers the abilities of Governments to fully implement reproductive health programmes and, at the individual level, limits people's access to basic social services, including reproductive health care. Many obstacles still need to be overcome, and countries need assistance from the international community, in terms of both human and financial resources to deal with those constraints. Many constraints have their roots in the unfavourable economic environment that most developing countries face. There are also constraints from within. As the reports from a number of countries indicate, massive bureaucracies hamper the implementation of the recommendations in the Programme of Action of the International Conference on Population and Development.

73. Likewise, accountability needs to be improved. The implementation of reproductive health programmes requires sectoral coordination at the central governmental level. It is clear that the difficult, and at times unfavourable, economic situation faced by many developing countries and countries with economies in transition, the dwindling resources allocated by the international donor community for official development assistance (ODA), and unfavourable internal conditions need to be fully addressed in order to successfully implement reproductive health programmes and to reach the goal of reproductive health by the year 2015.

74. Monitoring population programmes in general, and measuring progress in the implementation of reproductive health programmes in particular, are difficult in the absence of clear indicators. There is a strong need for the development of indicators in such areas as gender equality, reproductive health, women's participation, male involvement and resource mobilization.

75. The Programme of Action of the International Conference on Population and Development encourages Governments to commit themselves at the highest political level to achieving the goals and objectives of the Programme of Action and to take a lead role in coordinating the implementation, monitoring and evaluation

of follow-up actions (para. 16.7). Earlier studies undertaken by the United Nations have underscored the importance of political commitment in successful population and development interventions. 4/ Because of the importance of sustaining political commitment at all levels of society for the implementation of reproductive health programmes, it should be extended to include not only the central government but also government officials at various levels as well as parliamentarians, local and community leaders, unions and the media. Successful implementation of the recommendations in the Programme of Action of the International Conference on Population and Development depends on the commitment of all groups in civil society.

Notes

1/ Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

2/ Reports from the following 78 countries were received by 1 December 1995: Algeria, Argentina, Bangladesh, Benin, Bhutan, Bolivia, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, China, the Comoros, Costa Rica, Côte d'Ivoire, Cuba, Cyprus, Ecuador, Egypt, El Salvador, Equatorial Guinea, Ethiopia, Fiji, the Gambia, Ghana, Guatemala, Guinea, Guinea-Bissau, Haiti, Honduras, India, Indonesia, the Islamic Republic of Iran, Iraq, Jamaica, Jordan, Kenya, Lao People's Democratic Republic, Lithuania, Madagascar, Malawi, Maldives, Mali, Mauritania, Mauritius, Mexico, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, the Niger, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, the Philippines, Romania, Senegal, Seychelles, Sierra Leone, South Africa, the Sudan, the United Republic of Tanzania, Togo, Tunisia, Turkey, Turkmenistan, Uganda, Uruguay, Viet Nam, Zaire, Zambia and Zimbabwe.

3/ Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995 (A/CONF.177/20), chap. I, resolution 1, annex II.

4/ The national reports on population and development submitted to the secretariat of the International Conference on Population and Development showed that such commitment had expanded remarkably over the past 20 years. At the same time, most of the national reports stressed the need for even greater political support to population concerns, particularly in terms of raising social-sector public expenditures (see report of the Secretary-General of the International Conference on Population and Development on the synthesis of national reports on population and development (A/49/482), para. 57).

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FOLLOW-UP ACTIONS TO THE RECOMMENDATIONS OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT: REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

Work of the Inter-Agency Task Force for the Implementation of the Programme of Action of the International Conference on Population and Development

Report of the Task Force

SUMMARY

The present report has been prepared in response to Economic and Social Council resolution 1995/55, in which the Council endorsed the topic-oriented and prioritized multi-year work programme proposed by the Commission on Population and Development at its twenty-eighth session, including the preparation of an annual report on the work of the Inter-Agency Task Force for the Implementation of the Programme of Action of the International Conference on Population and Development. The topic for 1996 is "Reproductive rights and reproductive health, including population information, education and communication". As noted by the Council in the same resolution, the Task Force has been established by the Secretary-General to ensure system-wide coordination, collaboration and harmonization in the implementation of the Programme of Action.

The present report reflects the observations of 12 members of the Task Force regarding the implementation of the Programme of Action. It presents an

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overview of the Task Force; describes the activities of Task Force members in the area of reproductive rights and reproductive health; highlights critical issues; and emphasizes that effective implementation of the reproductive health programming approach is predicated on the identification of national needs and priorities at the country level, and will require a redoubling of collaboration within the United Nations system to meet the needs of countries.

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INTRODUCTION

1. In the new terms of reference of the Commission on Population and Development (E/1995/27, annex I, sect. IA), which were endorsed by the Economic and Social Council in its resolution 1995/55, the Commission is called upon to consider the reports of the meetings of inter-agency mechanisms established by the Secretary-General to ensure coordination, collaboration and harmonization in the implementation of the Programme of Action of the International Conference on Population and Development. In the same resolution, the Council noted that the Secretary-General had established an Inter-Agency Task Force for the Implementation of the Programme of Action, and it welcomed the intention of the Secretary-General to report to it through the Commission on the work of the Task Force so as to ensure system-wide cooperation in the implementation of the Programme of Action. Under the topic-oriented and prioritized multi-year work programme of the Commission, which was endorsed by the Council in the same resolution, the topic for 1996 is "Reproductive rights and reproductive health, including population information, education and communication".

2. The present report has been prepared in accordance with the above-mentioned mandates, and reflects the responses of 12 members of the Task Force (see annex I for list) to a questionnaire on the implementation of the Programme of Action, which specifically asked Task Force members to identify any areas where collaboration had met with difficulties. The responses indicate that a high level of collaboration has taken place and no problems have been encountered so far, and that collaboration is continuing in the field of reproductive rights and reproductive health.

I. OVERVIEW OF TASK FORCE ACTIVITIES

3. In its resolution 49/128, the General Assembly stressed the importance of continued and enhanced cooperation and coordination among all relevant organs, organizations and programmes of the United Nations system, including the specialized agencies, in the implementation of the Programme of Action of the International Conference on Population and Development. In response to paragraphs 20 and 22 of the same resolution, the Administrator of the United Nations Development Programme (UNDP), on behalf of the Secretary-General, asked the Executive Director of the United Nations Population Fund (UNFPA), who had served as Secretary-General of the International Conference on Population and Development, to convene and chair an inter-agency task force to address the implementation of the Programme of Action of the Conference. The Inter-Agency Task Force for the Implementation of the Programme of Action of the International Conference on Population and Development held its first meeting on 13 December 1994 and its second meeting on 25 July 1995; both meetings were held in New York. The Task Force has 14 members (see annex I). Five working groups were set up by the Task Force to address key areas for action corresponding to the objectives of the Programme of Action. An additional working group was established in response to the request of the Commission, at its twenty-eighth session, that the work of the Task Force be expanded to include migration issues. The working groups of the Task Force, together with the lead agencies and output of each group, are listed in the table.

Inter-Agency Task Force for the Implementation of the Programme of Action of the International Conference on Population and Development: activities of working groups during 1995

Title of working group/ Place and dates of meeting	Lead agency	Output
Working Group on Basic Education, with Special Attention to Gender Disparities (Paris, 7 March)	United Nations Educational, Scientific and Cultural Organization	Report of the meeting Guidelines on basic education with special attention to gender disparities Agency profiles and selected bibliography
Working Group on Policy-related Issues (New York, 3 May)	United Nations Population Fund	Report of the meeting Common advocacy statement
Working Group on A Common Approach to National Capacity-building in Tracking Child and Maternal Mortality (New York, 4 May)	United Nations Children's Fund	Report of the meeting Guidelines on a common approach to national capacity-building in tracking child and maternal mortality Agency profiles and selected bibliography
Working Group on Women's Empowerment (New York, 16 May)	United Nations Development Fund for Women	Report of the meeting Guidelines on women's empowerment Agency profiles and selected bibliography
Working Group on Reproductive Health (Geneva, 29 June)	World Health Organization	Report of the meeting Guidelines on reproductive health Agency profiles and selected bibliography
Working Group on International Migration (Geneva, 19 October)	International Labour Organization	Report of the meeting Guidance notes Agency profiles and selected bibliography

4. In the first year of its existence, the Task Force has demonstrated a collaborative and participatory approach. The working groups have functioned in a responsive and coordinated manner with a commitment to producing results in a timely fashion. The central focus of the work of the Task Force has been to enhance United Nations system-wide collaboration at the country level. To that end, the Task Force has prepared and disseminated a set of guidelines for the United Nations resident coordinator system, and has developed a common advocacy

statement on population and development. The Task Force has not encountered any problems in collaboration so far.

5. The guidelines address the following key areas of the Programme of Action: reproductive health; empowerment of women; a common approach to national capacity-building in tracking child and maternal mortality; and basic education, with special attention to gender disparities. The common advocacy statement, which underscores that population is an integral component of development strategies, was adopted by the Task Force and endorsed by the Administrative Committee on Coordination (ACC) at its second regular session of 1995 (see ACC/1995/23).

6. The main objective of the guidelines is to provide mechanisms in the field, particularly the resident coordinator system, with guidance on operationalizing the Programme of Action at the country level. The guidelines will facilitate more integrated planning and coordination of United Nations inputs for achieving the goals of the Programme of Action within a national development framework, and will help foster closer dialogue and collaboration between the United Nations system, Governments and other development partners, including bilateral agencies, non-governmental organizations and civil society. The guidelines build on arrangements that are already in place; throughout, their underlying concern is to seek ways to foster the enabling environment that is called for in the Programme of Action.

7. In September 1995, on the occasion of the first anniversary of the International Conference on Population and Development, the guidelines were distributed to all United Nations resident coordinators. The guidelines and the common advocacy statement have been widely disseminated within the United Nations system, with the recommendation that agencies and organizations ensure wide circulation among all their staff, particularly field staff; they are also available on the Internet. United Nations resident coordinators have been asked to share the documents with all interested parties, including representatives of Governments, donor agencies, non-governmental organizations and the private sector. Guidance notes on international migration, which discuss the principal substantive dimensions and activities of key organizations active in that area, have since been completed and disseminated.

8. Themes found in both the guidelines and the common advocacy statement include putting people first; promoting sustainable human development; reducing gender inequality and inequity; fostering accountability and transparency; developing common indicators that are critical to the monitoring of programme impact; strengthening country-level collaboration; enhancing national capacity-building; and facilitating dialogue between and among the United Nations resident coordinator system, Governments, non-governmental organizations, the private sector and civil society. The Task Force views feedback as essential to strengthening the collaborative process: by maintaining an open-ended information exchange, such as through feedback on the guidelines and the collection of information on lessons learned, the Task Force intends to develop a set of best practices that have been tested in the field and can be replicated in other settings, with adjustments to take account of local needs and priorities.

II. THE TASK FORCE AND REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH, AND POPULATION INFORMATION, EDUCATION AND COMMUNICATION

A. Working Group on Reproductive Health

9. Reproductive rights and reproductive health are critical to human well-being and human development. The Task Force established a Working Group on Reproductive Health, with the World Health Organization (WHO) as the lead agency, to address the key issues in the area and to develop a set of guidelines for the United Nations resident coordinator system to strengthen and facilitate reproductive health programming at the country level. The Working Group used the clear and comprehensive definition of reproductive health contained in the Programme of Action of the International Conference on Population and Development 1/ as the starting-point for its work:

> "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."

10. During its discussions, the Working Group emphasized that reproductive health is a crucial part of general health and is hence central to human development. It reflects health during childhood and adolescence, sets the stage for health beyond the reproductive years for both women and men, and has pronounced effects on the health of the next generation. The health of the newborn is largely a function of its mother's health, nutritional status and access to health care. Although reproductive health is a universal concern, it is of special importance to women, especially during the reproductive years. At each stage of life, individual needs differ. However, there is a cumulative effect across the course of life and events at each phase have important implications for future well-being. The Working Group emphasized that reproductive health always includes family planning and sexual health, and family planning will continue to be a central component of reproductive health care.

11. Other critical issues in reproductive health that emerged from discussions included the importance of basing strategies for the attainment of reproductive health on the underlying principles of human rights and gender equity, as well as on the operational principles of national ownership; the involvement of multiple perspectives and multiple actors, including service providers, users, planners, researchers and scientists; the use of participatory processes in the planning, implementation and evaluation of programmes, including close involvement of non-governmental organizations, community and youth groups and the private sector; and the importance of multisectoral action, with key partners contributing on the basis of their respective comparative advantages.

12. In developing the guidelines on reproductive health, the Task Force has recognized that the United Nations resident coordinator system is uniquely positioned to promote the recognition of the concept of reproductive health as central to general health and human development. The approach to development and the eradication of poverty must be holistic, just as the approach to reproductive health must, inevitably, be holistic and integrated. Thus, at the country level, the resident coordinator system must ensure that concerns pertaining to reproductive rights and reproductive health are integrated into all related development priorities and programmes.

13. Many factors influence reproductive health, and its attainment is not determined by interventions in the health sector alone. Socio-economic factors, including education, employment, living conditions, family environment, social relations, gender relations and legislation, as well as cultural and traditional practices, all affect reproductive health. As a result, it is critical that reproductive health programmes adopt an intersectoral as well as a multisectoral and multidisciplinary approach.

14. In amplifying what a reproductive health approach encompasses, the Task Force emphasizes in the guidelines that such an approach is people-centred and represents a shift from the earlier paradigm, which emphasized increasing the number of acceptors of family planning methods. In the new paradigm, the aim of interventions is to enhance reproductive rights and promote reproductive health rather than fertility control. That implies empowering women, including providing them with better access to education; involving women and young people in the development and implementation of programmes and services; reaching out to the poor, the marginalized and the excluded; and that men will assume greater responsibility for reproductive health.

15. The Working Group emphasized that countries need to assess their requirements through a wide-ranging, participatory process of national consultation involving all relevant constituencies; concomitantly, the identification of gaps and inadequacies as well as the need to strengthen linkages between programmes should be stressed. Based on such a consultative process, a list of national reproductive health priorities should be drawn up. National priorities create the framework for reproductive health programming. Striving for an integrated reproductive health approach does not imply that every service delivery point will be equipped to deal with every aspect of reproductive health: that is neither feasible nor practical. Instead, programmes must build on what they have and then proceed, guided by what people need most.

16. The precise configuration of reproductive health needs and concerns, as well as the programmes and policies adopted to address them, will vary from country to country and will depend upon an assessment of each country's situation and the availability of appropriate interventions. Globally, however, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health interventions are most likely to include attention to the issues of family planning, the prevention and management of sexually transmitted diseases, and the prevention of maternal mortality and morbidity. Reproductive health should also address such issues as harmful practices; unwanted pregnancy; unsafe abortion; reproductive tract infections, including sexually transmitted diseases/acquired immunodeficiency syndrome (AIDS); gender-based violence; infertility; malnutrition and anaemia; and reproductive tract cancers. Appropriate services must be accessible and must include information, education, counselling, the prevention, detection and management of health problems, care and rehabilitation. To translate the reproductive health concept into a reality, a minimum package of reproductive health services should be offered in the context of primary health care.

17. The International Conference on Population and Development was unique in the emphasis that it placed on reproductive rights and reproductive health. In addition, in both the Programme of Action and General Assembly resolution 49/128, Governments have emphasized the need for greater collaboration and cooperation. The Task Force has played a key role in promoting collaboration and cooperation among United Nations organizations and agencies in implementing the Programme of Action. One of the main reasons that the Task Force has worked well is that its members have been fully involved in deciding its work programme and the modalities for accomplishing it. The meetings of the Task Force have demonstrated the commitment of members to producing results by focusing on a work programme of specific, action-oriented tasks that are achievable in a relatively short period of time. Thus, the guidelines and common advocacy statement were developed in a timely manner, with an emphasis on providing pragmatic guidance to the United Nations resident coordinator system on the implementation of the Programme of Action at the country level. Early reports suggest that the guidelines are proving especially useful at the country level, since they provide a shared basis for United Nations organizations and agencies to collaborate on and coordinate their programming activities.

18. Although the guidelines on reproductive health focus on three different topics, "Women's empowerment", "Basic education with special attention to gender disparities" and "A common approach to national capacity-building in tracking child and maternal mortality", all three topics emphasize the following issues: identification of national priorities; empowerment of women; quality of care; advocacy; research and training; resource mobilization; monitoring and evaluation; enhancing the role of non-governmental organizations; and collaboration and coordination. Those issues constitute the key challenges facing both countries and international organizations as they seek to achieve the goals and objectives of the Programme of Action. The task of meeting them is complex; however, the Task Force is an effective mechanism for coordinating the response of developing countries and the United Nations system to those challenges.

B. Population information, education and communication

19. Population information, education and communication is a key instrument for attaining the goals of the Programme of Action of the International Conference on Population and Development, and is essential for empowerment, mobilization and behavioural change. It also plays a critical role in generating demand for further information and services and in increasing awareness among people of their rights and responsibilities, including their reproductive rights and responsibilities with respect to parenting, gender relations and safe sexual behaviour. Effective population information, education and communication, which requires understanding the target audience and the specific cultural context, forms the basis of any sound advocacy campaign, and must closely involve target groups, in particular youth and community groups, in its design, development, testing, implementation and evaluation.

20. The Task Force emphasizes that, in addressing the sexual and reproductive health needs of young people, reproductive health programmes should ensure that youth and adolescents have access to information, counselling and appropriate services. Young people of both sexes are especially vulnerable to reproductive health problems because of a lack of information and services. By targeting youth, population information, education and communication can play a key role in educating and raising awareness about reproductive rights and reproductive health and about individual and social responsibilities.

21. The Task Force, through the resident coordinator system, seeks to encourage Governments to increase resources for population information, education and communication, with a special emphasis on reaching young girls and adolescents and other underserved or neglected groups. Information, education and communication strategies that employ a multi-channel approach have proved effective, since information can be disseminated through various channels, traditional and modern, and can be packaged in various forms so as to allow both literate and illiterate audiences to understand key messages.

22. In paragraph 11.22, the Programme of Action notes that the tremendous potential of print, audio-visual and electronic media, including databases and networks such as the United Nations Population Information Network (POPIN), should be harnessed to disseminate technical information and to promote and strengthen understanding of the relationships among population, consumption, production and sustainable development. Within a week of its release, the guidelines for the United Nations resident coordinator system were placed on the POPIN gopher, the global headquarters of which is the Population Division of the United Nations Secretariat. The guidelines can be accessed through the Internet. The Task Force will continue, as appropriate, to electronically disseminate any relevant information that it develops on reproductive rights and reproductive health, population information, education and communication, and other key areas of interest.

23. In another instance of inter-agency collaboration, the World Bank, WHO and UNFPA, together with an international non-governmental organization, have produced an information card on reproductive health, which summarizes the commitments of the International Conference on Population and Development to reproductive rights and reproductive health; the goals for the year 2015;

special needs; rights and principles; actions for implementation, and the importance of working together in implementing the Programme of Action. The card, which is reproduced in annex II, has been widely distributed and is proving to be a useful information, education and communication tool.

C. Reproductive rights and reproductive health and population information, education and communication activities undertaken by member organizations of the Task Force

24. The International Conference on Population and Development has provided new impetus to advocacy and programming in the areas of reproductive rights and reproductive health, and population information, education and communication, and United Nations bodies are adjusting their programmes and activities to conform with the Programme of Action of the Conference. In addition to the collaborative efforts undertaken in the context of the Task Force, many of its members have intensified their activities in reproductive health in keeping with their respective mandates. All Task Force members are emphasizing collaboration and coordination with other United Nations bodies as well as with other development partners, particularly non-governmental organizations. The present section is based on the information supplied by members of the Task Force, and reviews their reproductive health and related activities.

1. United Nations Secretariat

25. The Department for Economic and Social Information and Policy Analysis and the Department for Policy Coordination and Sustainable Development of the United Nations Secretariat, as well as the Economic Commission for Europe (ECE), representing all the regional commissions, participate in the Task Force. Through its Population Division, the Department for Economic and Social Information and Policy Analysis regularly monitors fertility trends, contraceptive practice and mortality levels, by sex, as well as government policies related to population concerns. Every two years, the Population Division produces population estimates and projections, by age and sex, for all countries and areas of the world. It publishes gender-disaggregated statistics, conducts a variety of analytical studies that have a gender dimension, monitors population policies and organizes expert-group meetings dealing with gender issues. The Population Division serves as the global headquarters for POPIN, which facilitates Internet access. With both global and regional support from UNFPA, POPIN is a decentralized information and communication network for regional, national and non-governmental population information activities, including reproductive health and gender issues. The Population Division also serves as the substantive secretariat for the Commission on Population and Development, and is responsible for the preparation of the annual World Monitoring Report.

26. Within the Department for Policy Coordination and Sustainable Development, the Division for the Advancement of Women served as the secretariat for the Fourth World Conference on Women (Beijing, 4-15 September 1995), and the Division for Social Policy and Development served as the secretariat for the World Summit for Social Development (Copenhagen, 6-12 March 1995). The

Copenhagen Declaration, 2/ the Programme of Action of the World Summit for Social Development 3/ and the Beijing Platform for Action 4/ contain important provisions for reproductive health, and amplify the message of the International Conference on Population and Development; recent conferences also call for the development of comprehensive national strategies for improving reproductive health care and child health-care services, in keeping with the Programme of Action of the Conference. The Division for Sustainable Development is responsible for monitoring and facilitating the implementation of Agenda 21, 5/ and other outcomes 6/ of the United Nations Conference on Environment and Development. Agenda 21 sets out reproductive health objectives, including the provision of safe and effective health care and affordable, accessible services, as appropriate, in keeping with freedom, dignity and personally held values.

27. ECE, which for the past year has served on the Task Force as the focal point for all the regional commissions, has been conducting research on fertility and the family. With funding from UNFPA, ECE has initiated a series of activities leading to the collection and analysis of comparable survey data on fertility and the family in various ECE member States, including 10 countries with economies in transition. Although ECE has only a small demographic research unit working on reproductive health, the area is of special concern in Central and Eastern Europe, where there is a need for much more research on reproductive health issues, particularly family planning, and on the supervision and supply of services, including the transition from abortion to the use of contraceptive services. ECE has been collaborating with WHO in this work, and plans to intensify its collaboration with other international organizations with expertise in reproductive rights and reproductive health, and population information, education and communication.

2. United Nations Children's Fund

28. In its follow-up to the International Conference on Population and Development, the United Nations Children's Fund (UNICEF) is pursuing close collaboration with partners in a variety of sectors, with a special focus on girls' education; women's empowerment; primary health care, including reproductive health; and the tracking of progress in reducing child and maternal mortality. UNICEF support for women's health activities emphasizes working with women's organizations at the community level and assisting women's organizations in implementing efforts on information, education and communication, and in developing financing mechanisms for purchasing health care. UNICEF efforts in the area of adolescent health care seek to build stronger dialogue and partnership among young people, parents, educators, health providers and community leaders on health, including reproductive health. They also seek to help ensure that adolescents have access to the information, skills and services that they need to protect and promote their own health and, eventually, the health of their children. UNICEF supports school health programmes that emphasize skills-based health education, including reproductive health education. UNICEF works closely with WHO, UNFPA and non-governmental organizations in strengthening approaches to youth and women's health. UNICEF served as the lead agency of the Task Force's Working Group on a Common Approach to National Capacity-Building in Tracking Child and Maternal Mortality, and is also a co-sponsor of UNAIDS.

3. United Nations Development Programme

29. UNDP focuses attention on mainstreaming gender in all its programmes and on furthering the advancement of women. By fully mainstreaming gender concerns, UNDP seeks to empower women and contribute to an enabling environment for their advancement, especially by achieving gender equity in decision-making; developing capacity; recognizing women's power as agents of change; improving access to economic resources and assets; halting the feminization of poverty; assisting women in crises; and creating legal frameworks that facilitate gender equality and equity. Although UNDP has only a modest direct involvement in reproductive rights and reproductive health, it makes an important indirect contribution to the achievement of such goals through advocacy and support for the eradication of poverty and the mainstreaming of gender into development programmes and policies. UNDP is involved in supporting education in all regions, and collaborates with UNFPA and other organizations in addressing the special needs of youth and adolescents. In human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS) prevention, UNDP has helped strengthen not only the capacity of Governments to respond to the epidemic but also that of non-governmental organizations and community-based organizations, by enhancing their capacity to monitor, document, evaluate and enhance programme design and implementation. UNDP is also a co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

4. United Nations Development Fund for Women

30. The United Nations Development Fund for Women (UNIFEM) serves as a catalyst for ensuring the appropriate involvement of women in mainstream development activities, and supports innovative and experimental activities benefiting women in line with national and regional priorities. To foster the political empowerment of women, UNIFEM advocates for gender equity and the reform of legal and policy frameworks, codes and instruments. Since the Conference, at which the empowerment of women was recognized as fundamental to the success of population-related programmes, UNIFEM has become more involved in women's health-related issues, although it is only indirectly involved in reproductive health programmes and issues. UNIFEM served as the lead agency for the Task Force's Working Group on Women's Empowerment. At the Fourth World Conference on Women, UNIFEM, in partnership with UNFPA, sponsored a youth day workshop on the reproductive health of African adolescents. In a joint effort with UNFPA, UNIFEM is also developing programmes that link the human rights framework to women's reproductive rights.

5. United Nations Population Fund

31. UNFPA support for reproductive health is based on a public-health, pragmatic and participatory approach. Since the Conference, UNFPA has, with the approval of its Executive Board, oriented its programme focus and operational strategies to three main areas: reproductive health, including family planning and sexual health; population and development strategies; and advocacy. UNFPA will support all aspects of family planning at primary, secondary and tertiary levels. Support for other components of reproductive health will be

concentrated at the primary health-care level. Recognizing the need to strengthen referral services for the evaluation and treatment of reproductive health problems that cannot be managed at the primary health-care level, UNFPA will promote appropriate strengthening of reproductive health services at the secondary and tertiary levels. Specifically, UNFPA will support the following information and service-delivery components of reproductive health programmes: the full spectrum of family-planning information and services, including counselling and follow-up services aimed at couples and individuals; prenatal, delivery and postnatal care of mothers at the primary health-care level, with appropriate referral for the management of obstetric complications; the prevention of abortion, management of consequences of abortion, and post-abortion counselling and family planning; prevention of reproductive tract infections, including sexually transmitted diseases and the treatment of symptomatic infections, as part of primary health care, with appropriate referral for follow-up; prevention of HIV/AIDS as part of primary health care, with appropriate referral for follow-up; prevention of infertility and sub-fecundity, as part of primary health care, with appropriate referral for follow-up; routine screening and referral for other conditions of women's reproductive health; and active discouragement of harmful practices, such as female genital mutilation. In order to assist countries in the development of effective reproductive health programmes, UNFPA strongly encourages further strengthening of collaboration and coordination with partners in the United Nations system, bilateral agencies and non-governmental organizations. UNFPA has integrated HIV/AIDS-prevention components in its ongoing reproductive health and family planning programmes in 103 countries. It supports a wide spectrum of HIV/AIDS prevention activities, including information, education and communication activities, in-school and out-of-school education, counselling, distribution of condoms, and training for medical staff and other health-service providers. Several of these activities have been undertaken in collaboration with non-governmental organizations and other United Nations organizations and agencies. UNFPA served as the lead agency for the Task Force's Working Group on Policy-related Issues, and is a co-sponsor of UNAIDS.

6. World Food Programme

32. Many World Food Programme (WFP) activities directly concern reproductive rights and reproductive health, although WFP has no specific programme in those areas. WFP supports mother and child health programmes in countries throughout the world, providing food aid not only as a nutritional supplement but also as an incentive for women to attend education sessions on health, including reproductive health and family planning, and nutrition. In emergency and refugee situations, to which a major portion of its resources are directed, WFP has a special commitment to meeting the needs of women, including their reproductive health needs. WFP is also supporting pilot projects to assist HIV/AIDS victims and their dependants in Uganda and the United Republic of Tanzania. Increasingly, non-governmental organizations are involved in the execution of WFP activities.

7. Office of the United Nations High Commissioner for Refugees

33. With the new impetus provided by the Programme of Action, the Office of the United Nations High Commissioner for Refugees (UNHCR) is working jointly with United Nations organizations and non-governmental organizations in promoting, advocating and implementing reproductive health activities in refugee and emergency situations. In June 1995, UNHCR, in collaboration with UNFPA, UNICEF and WHO, organized an inter-agency symposium on reproductive health (see also paras. 46-50 below). The symposium underscored the need to coordinate reproductive health activities among all groups so as to ensure complementarity and cost effectiveness, and highlighted the importance of community participation in the planning and delivery of reproductive health services. With UNHCR as coordinator, an inter-agency working group will organize and facilitate reproductive health services in refugee situations, including information exchange, advocacy, planning, training, assessment, monitoring, coordination, research and evaluation. Among its priority tasks will be the operationalization of a field manual on reproductive health in refugee situations. To strengthen coordination, the working group will also collaborate with other bodies, such as the WHO Consultative Group on Reproductive Health, the Reproductive Health for Refugees Consortium and the Working Group on Reproductive Health Kits.

8. International Labour Organization

34. The International Labour Organization (ILO) policies and programmes are based on the premise that success in protecting and promoting reproductive health is linked to social and economic factors, including education, training, employment, working conditions and gender equality in labour markets. ILO promotes and provides technical support to its constituents in order to enable them to design, develop and implement comprehensive policies and programmes that link population and reproductive health concerns to social and economic goals and achievements. Employers are assisted in adopting appropriate workplace rules and mechanisms both to eliminate reproductive health hazards and to promote family welfare and planning through education and access to services. Workers' organizations are strengthened to promote and implement the education of workers on population, reproductive health and gender issues. The special needs of youth are being addressed by integrating modules on reproductive rights and reproductive health, population issues and family life in the curricula of vocational training programmes. A priority issue for ILO is the design, development and dissemination of training materials on women workers' rights and resources for women's organizations in the informal and rural sectors. ILO will continue to strengthen and build national capacity to develop, execute, monitor and evaluate programmes.

9. Food and Agriculture Organization of the United Nations

35. The Food and Agriculture Organization of the United Nations (FAO) promotes food security, nutrition and improvement of the quality of life for rural populations, and stresses the linkages between population issues and reproductive health. FAO has emphasized the need for ensuring that reproductive

health services are available to rural people, and that both women and men are included in the design of reproductive health services. FAO is collaborating with other United Nations organizations and agencies, along with non-governmental organizations, in implementing its programmes. Under the UNFPA-funded project "Integration of population education into programmes for rural youth", FAO is supporting population education in the jungle area of Iquitos, Peru, and among the H'mong ethnic minority youth and rural youth in Viet Nam. Rural youth population activities are also being expanded to other countries in Africa, Asia and South America. Training for youth leaders covers issues pertaining to the relationship between population and the environment as well as reproductive health and responsible parenthood. FAO was the first agency to initiate detailed sectoral analysis of the socio-economic impact of HIV/AIDS on rural economies, and has identified both specific and general characteristics of vulnerable households and farming systems. It has demonstrated the importance of home remittances from migrant workers for household food security, food production and nutritional well-being, and consequently the importance of their loss to HIV/AIDS-related morbidity and mortality.

10. United Nations Educational, Scientific and Cultural Organization

36. The United Nations Educational, Scientific and Cultural Organization (UNESCO) plays a critical role in supporting the educational, cultural and scientific aspects of reproductive health. Emphasis is on collaboration with the United Nations system and non-governmental organizations in enhancing the quality of life. The importance of attitudinal change on the basis of multicultural differences is stressed, together with the need to reach out to the public to advocate for reproductive health. UNESCO emphasizes the importance of networking among countries to share expertise and experiences in national capacity-building. In collaboration with UNFPA, UNESCO has promoted population information, education and communication projects in Africa, the Arab States and Asia, most of which have a component on reproductive rights and reproductive health. UNESCO has also provided support to Governments of developing countries for policy and planning in school-based HIV/AIDS-prevention education. UNESCO served as the lead agency for the Task Force's Working Group on Basic Education with Special Attention to Gender Disparities. It is also a co-sponsor of UNAIDS.

11. World Health Organization

37. WHO has a unique role within the United Nations system with respect to advocacy, normative functions, research and technical cooperation in reproductive health. In its advocacy role, WHO promotes understanding of the universality of reproductive health needs and their crucial importance in human development. As the main agent for health research within the United Nations system, WHO will continue to conduct, support, promote and evaluate research in reproductive health, and to coordinate the global research efforts in this field. In the area of reproductive health technologies, particular emphasis is being given to methods that match women's perceived needs and priorities,

including user-controlled methods that can also protect against sexually transmitted diseases, post-ovulatory methods, and safe male methods that enable men to share responsibility for fertility regulation and disease prevention. The normative functions of WHO include the development of policies, strategic approaches, norms, standards and guidelines. WHO will also continue to develop technical, managerial and policy guidelines on various aspects of reproductive health. WHO has also developed innovative methodologies for countries to identify national and district-level reproductive health needs. In collaboration with other organizations, WHO will develop methodologies for assessing reproductive health, and will formulate both qualitative and quantitative indicators for measuring the reproductive health status and behaviour of populations as well as the effectiveness of programmes and interventions. WHO will provide technical support to developing countries, and will strengthen their national capacity for formulation, implementation, monitoring and evaluation of comprehensive national reproductive health policies and programmes. WHO collaborates with a number of United Nations organizations and non-governmental organizations, particularly in reproductive health and adolescent health programmes. WHO supports numerous activities in the area of HIV/AIDS and sexually transmitted diseases, and is a co-sponsor of UNAIDS.

38. In advancing the Programme of Action, the Pan American Health Organization (PAHO) has focused primarily on activities related to quality of care. Two major initiatives undertaken in this area during 1995 were (a) the planning and execution of a regional meeting in San Salvador on incorporating a gender perspective in the quality of care in reproductive health services in Latin America, and (b) the mobilization of funding for conducting operational research in two countries in Latin America on gender differences in health-care quality. The San Salvador meeting, inter alia, proposed criteria and indicators for measuring the degree to which quality of care in reproductive health services incorporates a gender perspective. The operational research is aimed at providing comparative information on the response of public health services to both gender-specific and non-gender-specific health needs of men and women in relation to illness prevention, health promotion and social behaviour.

12. World Bank

39. Reproductive health activities constitute a significant portion of all World Bank lending for population, health and nutrition activities. During fiscal 1994, more than 40 per cent of all lending for population, health and nutrition supported reproductive health activities. The operations research, situation analyses and field-based pilot projects of the World Bank assist programme managers in assessing needs, instituting or modifying services and in determining the effects of interventions on health systems and health status. In addition to providing support for reproductive health activities through project lending, the World Bank Economic Development Institute organizes training activities that strengthen national capacities to design and implement policies and programmes in this field. The World Bank actively seeks and supports collaboration among donor agencies and local non-governmental organizations in promoting awareness of reproductive health issues and improving effectiveness of projects with reproductive health components. The World Bank is the single largest source of external funding for the prevention and control

of HIV/AIDS/sexually transmitted diseases in the developing world. The principal mechanism for the direct support of the World Bank to HIV/AIDS prevention activities is through its lending, most of which is done at highly concessional terms. The World Bank has sponsored several studies on the social and economic impact of HIV/AIDS and the cost effectiveness of prevention and care interventions, and is also a co-sponsor of UNAIDS.

III. ADDITIONAL COLLABORATION IN REPRODUCTIVE HEALTH

40. The present section reviews certain joint and collaborative activities undertaken by United Nations organizations and agencies in reproductive rights and reproductive health, and population information, education and communication. Some of these fall outside the immediate purview of the Task Force; nevertheless, they underscore the wide scope of collaboration and coordination in the United Nations system.

41. Discussions are under way concerning two collaboration mechanisms involving UNICEF, UNFPA and WHO. To strengthen cooperation among the three organizations, UNFPA has proposed that the three organizations agree on a joint health policy framework and institute a high-level inter-secretariat consultative mechanism to promote the coordination of policy approaches, strategies and activities; ensure regular exchange of information on key developments; and help ensure that an overall policy framework, as defined by WHO, guides the strategies and activities of the three organizations. The consultative mechanism will help to ensure maximum synergy and complementarity of the programmes of UNICEF, UNFPA and WHO, and will enhance, through collaboration, the effective delivery of assistance at the country level. UNFPA has proposed the consultative mechanism independent of its other proposal concerning membership of the UNDP/UNFPA Executive Board in the UNICEF/WHO Joint Committee on Health Policy (JCHP).

42. JCHP, inter alia, helps guide UNICEF and WHO on the types of health programmes that should most appropriately receive their complementary or joint support. A tripartite intergovernmental committee on health policy composed of representatives from the executive boards of UNICEF, UNFPA and WHO would have several distinct advantages. Such a committee would provide the only venue where members of all three executive boards could meet jointly to discuss health policy issues common to the three organizations. It would also help to sharpen the focus of collaborative activities in the areas of child and reproductive health, and would enhance inter-agency collaboration in achieving the health and related social goals of recent international conferences and summits, including the World Summit for Children and the International Conference on Population and Development. Such a committee would also strengthen activities in advocacy, population and development strategies and in reproductive health programmes. Finally, it would ensure that policy advice and strategies are complementary, in harmony and have a synergistic effect, especially at the country level.

A. Reproductive rights and reproductive health and women's empowerment

43. Women bear by far the greatest burden of reproductive health problems. Among women of reproductive age, 36 per cent of the healthy years of life lost are lost due to reproductive health problems, such as unregulated fertility, maternal mortality and morbidity, and sexually transmitted diseases, including HIV/AIDS. By contrast, the equivalent figure for men is 12 per cent. 7/ Biological factors alone do not explain women's disparate burden: their social, economic and political disadvantages and the denial of their reproductive rights have a detrimental impact on their reproductive health. The empowerment of women is a fundamental prerequisite for their reproductive health, which will not be significantly improved in the absence of gender equity and equality. Because men's social and sexual behaviour affects women's reproductive health directly, reproductive health programmes, while catering for the specific needs of women, will also need to pay special attention to the roles and responsibilities of men and the need for them to assume greater responsibility for their sexual and reproductive behaviour and their social and family roles.

44. The Task Force, in addition to developing the guidelines on reproductive health, has developed guidelines on women's empowerment for the United Nations resident coordinator system. With the aid of the guidelines and in conjunction with guidelines on basic education and tracking child and maternal mortality, the United Nations resident coordinator system can both promote and facilitate programming that increases women's access to resources, education and employment, and protects and promotes their human rights and fundamental freedoms so that they are able to make choices free from coercion or discrimination. At the same time, greater effort is needed to facilitate women's involvement in programme development and implementation so that they become participants rather than the objects of intervention.

B. Reproductive rights and reproductive health and refugee/emergency situations

45. The important issue of the reproductive health-care needs of refugees, migrants and displaced persons is highlighted in paragraph 7.11 of the Programme of Action of the Conference:

> "Migrants and displaced persons in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights. Services must be particularly sensitive to the needs of individual women and adolescents and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence."

46. Arising from the recognition that the provision of reproductive health services is as important as providing food, clean water, shelter, sanitation and primary health care in refugee and emergency situations, a new impetus has been given to reproductive health concerns in refugee and emergency situations, including the convening of an inter-agency symposium on reproductive health in refugee situations. Organized by UNHCR and UNFPA in collaboration with UNICEF

and WHO, the symposium took place in Geneva from 28 to 30 June 1995, and was attended by representatives of 50 governmental, non-governmental and private organizations.

47. The symposium identified the main reasons for the lack of a systematic strategy for the provision of comprehensive health care in refugee situations: the low priority accorded to it by organizations specialized in emergency response; insufficient field staff with appropriate training; limited funding and resource allocation; insufficient coordination among national authorities, non-governmental organizations and United Nations organizations and agencies in the country of asylum; and consideration of family planning as a sensitive issue in post-conflict situations without seeking the views and support of refugee women.

48. To overcome these limitations, the recommendations offered included the following: essential minimum reproductive health services should be made available at the outset of all refugee operations through the Minimum Initial Service Package; reproductive health activities and services should be implemented in full and integrated within existing primary health-care services as soon as possible; if needed and to the extent possible, reproductive health services should also be made available to the local population surrounding the refugee settlements; and close collaboration should be established with local authorities to facilitate the harmonization and sustainability of services. In addition, adequate training and cultural sensitivity on the part of service providers need to be recognized as essential to the quality of reproductive health care, together with respect for confidentiality and privacy. Services should be located appropriately, and adequate equipment as well as continuous and regular supplies should be provided. Community participation in the planning and delivery of reproductive health services is essential, and should be ensured. The coordination of reproductive health activities among all groups providing services is critical to ensuring complementarity and cost effectiveness; hence, a focal point on reproductive health should be identified as early as possible in all refugee operations.

49. The existence of basic human rights in the area of health, including reproductive health, was highlighted, and various provisions relative to reproductive health contained in international and regional human rights instruments were illustrated. It was emphasized that refugees are often in need of complete health care owing to the risks of marginalization in the local community and their inability to pay for care during exile. The symposium also emphasized the protection of human rights as a means of promoting public health, and stressed the key role of appropriate information, education and communication strategies in achieving it.

50. In conjunction with the above-mentioned symposium, UNHCR and UNFPA signed a memorandum of understanding establishing a framework for collaboration for the benefit of persons in refugee situations. UNHCR and UNFPA will jointly develop strategies and programmes of advocacy for reproductive health information and service needs, and for combating sexual violence; develop strategies to promote reproductive health among adolescents and young people; organize joint assessment, monitoring and evaluation missions relating to reproductive health information and services; develop field manuals on the provision of reproductive

health information and services, including reproductive health counselling and clinical activities; facilitate coordination at the field level through the establishment of coordination committees, with the participation of UNHCR, UNFPA, other concerned United Nations bodies, and non-governmental organizations for the purpose of enhancing the provision of reproductive health information and services; and develop strategies to ensure the integration of reproductive health information and services into the relevant programmes of other organizations.

C. Reproductive rights and reproductive health and HIV/AIDS prevention

51. An effective reproductive health approach is closely linked with an HIV/AIDS-prevention component. Research indicates that biologically, epidemiologically and socially, women are more vulnerable to HIV than are men. Women's generally subordinate role in the family and society renders them especially at risk of HIV infection. Thus, it is essential that reproductive health programmes provide women with the information, services and support necessary to protect themselves. At the same time, countries need to develop multisectoral programmes and strategies targeting those factors that maintain the social, cultural and sexual subordination of women and girls. In the absence of a cure for HIV, knowledge plays a key role in HIV/AIDS prevention. HIV transmission can be significantly reduced through informed and responsible behaviour. Thus, effective information, education and communication is critical in HIV/AIDS-prevention and control strategies.

52. Recognizing that inter-agency cooperation is vital in ensuring the mobilization of resources and effective implementation of a coordinated programme of activities throughout the United Nations system, UNAIDS will draw upon the experience and strengths of its six co-sponsors and will build on their comparative advantages to develop its strategies and policies, which will be incorporated in turn into their programmes and act vities. Several members of the Task Force have already established close linkages with UNAIDS; some have already seconded staff to it. The six co-sponsors of UNAIDS (UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank) are also integrally involved in the work of the Task Force.

IV. CRITICAL ISSUES AND CHALLENGES

53. Based on the foregoing discussion of reproductive rights and reproductive health, including population information, education and communication, several key issues and challenges can be distinguished that the Task Force needs to address in implementing the Programme of Action of the Conference and, more specifically, in attaining the goal of enabling all countries to make reproductive health accessible through the primary health-care system to all individuals of appropriate ages as soon as possible and no later than the year 2015. All agencies and sectors have roles and responsibilities in promoting and enhancing reproductive health. In its advocacy work, the Task Force, through the United Nations resident coordinator system, can emphasize that the determinants of poor reproductive health include poverty, gender and other forms

of inequity, social injustice, marginalization and development failures, as well as the lack of access to quality health services. A multisectoral and multidisciplinary approach is essential if the objective of the Programme of Action of providing reproductive health care for all by the year 2015 is to be met.

54. Some of the key challenges for meeting that goal include the identification of national priorities; the empowerment and involvement of women; quality of care; advocacy; research and training; resource mobilization; monitoring and evaluation; the enhancement of the role of non-governmental organizations; and collaboration and coordination. The Task Force mechanism could be drawn upon to address those challenges as follows:

(a) Identification of national priorities: the Task Force, through the United Nations resident coordinator system, will continue to emphasize the need to assist countries in assessing and identifying their reproductive health needs and priorities. The process should be participatory, involving all key organizations, and should ensure the inclusion of non-governmental organizations, community and youth groups, women's organizations, the private sector and civil society. Additionally, an incremental, integrated and pragmatic programming approach based on national needs and available resources should be encouraged;

(b) Empowerment and involvement of women: the empowerment of women is a fundamental prerequisite for their reproductive health. As already noted, the greatest burden of reproductive ill-health falls on women. It is critical that reproductive health programmes emphasize the empowerment of women, and ensure that they specifically address the special needs of girls and women, as well as those of other underserved groups, such as youth and adolescents; the rural and urban poor; persons in remote or neglected areas; and migrants, refugees and displaced persons. Increasing the role and responsibility of men in reproductive health, parenting and the prevention of AIDS and sexually transmitted diseases will also have a positive impact on the health of women. Attention must also continue to be focused on eradicating gender-based violence and other harmful practices detrimental to the health and well-being of girls and women. Women must also be afforded opportunities to be involved in the design, development, implementation and evaluation of reproductive health programmes. The Task Force, through the United Nations resident coordinator system, can play a key role in ensuring that development programmes emphasize the empowerment of women and focus attention on promoting and enhancing their reproductive health;

(c) Quality of care: the people-centred focus of the Programme of Action emphasizes the provision of high quality of care with regard to reproductive health information and services; in particular, the Task Force, through the United Nations resident coordinator system, must work to ensure that a constellation of services is easily accessible, and takes into account and is responsive to the user perspective, especially that of women, youth and adolescents. In focusing on the delivery of high-quality services and care, the United Nations resident coordinator system should draw upon the comparative advantages of non-governmental organizations and other concerned groups and organizations. Non-governmental organizations have a special contribution to

make in monitoring the quality of care and progress towards achieving national goals, as well as in introducing new and innovative methodologies, including qualitative indicators for measuring the quality of care and user satisfaction. Effective information, education and communication, targeted to meet the needs of specific audiences and counselling, are also key elements of reproductive health programmes that emphasize quality of care;

(d) Advocacy: in keeping with the Programme of Action, the Task Force and the United Nations resident coordinator system will continue vigorous advocacy for sustained political commitment to reproductive health, including, as appropriate, the promotion of legislation and cultural practices beneficial to reproductive health. A shared understanding of reproductive health will need to be developed and promoted through national and local consensus-building to lay the foundation for dialogue and programme development. The purpose of advocacy is to draw the attention of the community to the challenges of reproductive health, and to point decision makers towards nationally relevant solutions. One key objective of advocacy is to create a supportive and enabling cultural, social and political environment for reproductive health. The United Nations resident coordinator system has a key role to play in promoting the concept of reproductive health as central to general health and human development. Advocacy can also provide the rationale for greater allocation of resources for action in reproductive health;

(e) Research and training: action-oriented research responsive to country needs is essential. In addition to being responsive to national priorities, the global research agenda should also focus on the development and transfer of reproductive health technologies suited to local conditions. To ensure the effective implementation of the reproductive health approach, adequate training is required for programme managers and service providers. Training for reproductive health workers will need to focus on improving both technical and interpersonal skills. The adoption of a reproductive health approach may require changes in attitudes, as well as new skills and training. Managerial and administrative changes will also be needed, since integrated services, at least initially, can impose greater burdens on already overworked staff and will require attention to planning and logistics in order to ensure the availability and continuity of services;

(f) Resource mobilization: in order to assist countries in implementing reproductive health programmes, the United Nations system will need to assist in the mobilization of additional resources, both financial and human. To do so, non-traditional sources of funding will need to be explored. At the same time, innovative approaches will be needed, such as combining programmes to maximize use of resources, sharing costs with users, creating employer-based reproductive health programmes, and adopting community-based service delivery and social marketing. Many of these approaches have already been used and have proved successful. The Task Force can play a role in encouraging experimental and innovative schemes, as well as in disseminating the lessons learned from approaches that have succeeded. Because the demands for official development assistance are ever increasing and competing, countries and agencies alike need to build on available resources while continually exploring new avenues;

(g) Monitoring and evaluation: close monitoring and evaluation of programmes, together with course corrections as appropriate, will ensure the effective delivery of reproductive health services and care. The United Nations resident coordinator system should support national capacity-building for monitoring progress in country programmes in ways that are helpful to programme management and useful at the point of delivery of the intervention. The international community has already defined a number of indicators relevant to reproductive health, and WHO is working on additional qualitative and quantitative indicators for global monitoring;

(h) Enhancement of the role of non-governmental organizations: non-governmental organizations and private organizations have a major contribution to make in the development and implementation of strategies for reproductive health. Governments and international agencies need to capitalize on areas of comparative advantage of non-governmental organizations as they look for partners to complement and supplement their development efforts. Frequently, through their innovative, flexible and responsive programme design and implementation, non-governmental organizations have been able to ensure grass-roots participation as well as to interact with and serve constituencies that may be underserved or difficult to reach through government channels. The United Nations resident coordinator system can play a lead role in increasing the involvement and participation of non-governmental organizations and private-sector organizations in reproductive health programming, by supporting networking, information sharing and the establishment of councils or committees that facilitate and enhance dialogue and joint programming efforts among United Nations organizations, Governments and non-governmental organizations;

(i) Collaboration and coordination: in order to effectively and harmoniously implement the reproductive health programming approach in a strategic and holistic manner, United Nations agencies and organizations will need to redouble their efforts in collaborating and coordinating their activities. This will include increasing the involvement of non-governmental organizations, the private sector, youth and community groups, women's organizations and civil society in the planning, implementation, monitoring and evaluation of reproductive health programmes. Another area for the support of the Task Force and the resident coordinator system is in strengthening the role and contribution of regional institutions, including the regional commissions and the regional banks, in reproductive health advocacy and programming. It is essential that, in translating the concept of reproductive health, consistency and complementarity guide the United Nations system. In particular, it should be ensured that national counterparts do not receive conflicting messages from different United Nations agencies and organizations. Greater information sharing, networking, coordinated planning and harmonization of programming cycles will contribute substantially to enhancing collaboration, coordination and complementarity among United Nations agencies and organizations.

55. As indicated in paragraph 54 above, the challenges that lie ahead are both complex and numerous. Perhaps the most important challenge facing the United Nations system, the one on which success will most depend, is that of achieving and sustaining close collaboration and coordination among all United Nations agencies and organizations and, indeed, with all other development partners. Thus far, the Task Force has encountered no collaboration problems. However, it

will continue to emphasize the need for the United Nations system to work in a collaborative and coordinated manner with Governments, non-governmental organizations, the private sector, community and youth groups, and civil society.

V. CONCLUSION

56. In producing the guidelines for the United Nations resident coordinator system and the common advocacy statement, the Task Force has taken a major step forward. In many respects, however, the work of the Task Force has only just begun. The challenge ahead will include close monitoring and ensuring that the United Nations resident coordinator system continues to work effectively to assist countries in implementing the Programme of Action, including rapidly advancing to meet the Programme of Action's goal of making reproductive health care accessible to all by the year 2015.

57. This must be a joint endeavour: no organization can single-handedly meet the goals and objectives of the Programme of Action. In just over a year, the Task Force has demonstrated that United Nations organizations and agencies can collaborate and coordinate their activities in meeting a common goal, and furthermore that they can do so harmoniously while capitalizing on their areas of comparative advantage. The guidelines prepared by the Task Force do not conflict with the individual mandates of member organizations; rather, they enhance complementarity and aim at strengthening coordination while promoting an enabling environment for the effective implementation of the Programme of Action. The Task Force will continue its commitment to ensuring that all its development efforts in implementing the Programme of Action remain people-centred.

58. A system-wide action plan to provide coordinated assistance to countries in translating the outcomes of recent United Nations global conferences into concrete national policies and programmes has been agreed by all the United Nations agencies. The unifying theme of the action plan agreed by ACC to follow up on those conferences is the provision of assistance to countries in a concerted attack on poverty. As part of this action plan, inter-agency task forces will be established to address (a) basic social services, (b) employment and sustainable livelihoods, and (c) an enabling environment for social and economic development. The existing Inter-Agency Task Force for the Implementation of the Programme of Action, chaired by UNFPA, will be expanded to cover social services for all and to help further the commitments to strengthening health and basic education services made at the above-mentioned conferences. The other two task forces - covering items (b) and (c) above - will be chaired, respectively, by the ILO and the World Bank.

Notes

1/ Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), para. 7.2.

2/ Report of the World Summit for Social Development, Copenhagen, 6-12 March 1995 (A/CONF.166/9), chap. I, resolution 1, annex I.

3/ Ibid., annex II.

4/ Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995 (A/CONF.177/20), chap. I, resolution 1, annex I.

5/ Report of the United Nations Conference on Environment and Development, Rio de Janeiro, 3-14 June 1992, vol. I, Resolutions Adopted by the Conference (United Nations publication, Sales No. E.93.I.8 and corrigenda), resolution 1, annex II.

6/ Ibid., annexes I and III.

7/ See Inter-Agency Task Force for the Implementation of the Programme of Action of the International Conference on Population and Development, "Guidelines on reproductive health", in Guidelines for the United Nations Resident Coordinator System (New York, United Nations Population Fund, 1995).

Annex I

LIST OF MEMBERS OF THE INTER-AGENCY TASK FORCE FOR THE IMPLEMENTATION OF THE PROGRAMME OF ACTION OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

United Nations Secretariat a/

- Department for Policy Coordination and Sustainable Development
- Department for Economic and Social Information and Policy Analysis
- Economic Commission for Europe b/

United Nations Children's Fund a/

United Nations Development Programme

United Nations Development Fund for Women a/

United Nations Environment Programme

United Nations Population Fund a/

World Food Programme

Office of the United Nations High Commissioner for Refugees a/

International Labour Organization a/

Food and Agriculture Organization of the United Nations a/

United Nations Educational, Scientific and Cultural Organization a/

World Health Organization a/

- Pan American Health Organization

World Bank a/

International Monetary Fund

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a/ Replied to the questionnaire sent out by the Task Force secretariat.

b/ Representing the regional commissions.

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Annex II

INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT: COMMITMENTS TO REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH a/

Facts

1. Every year, 500,000 women die, one every minute, from pregnancy-related causes, 99 per cent of them in developing countries.

2. There are 120 million women who say they do not want to be pregnant but are not using family planning.

3. Each year, 20 million unsafe abortions occur, resulting in tens of thousands of deaths and millions of disabilities.

4. More than 15 million girls, aged 15 to 19, give birth every year.

5. Over 300 million new cases of sexually transmitted diseases occur every year, affecting 1 of every 20 adolescents.

6. By the year 2,000, up to 40 million people could be HIV-infected.

Reproductive health for all by the year 2015

Reproductive health, including family planning and sexual health, through the primary health-care system, should include:

1. Quality family planning, including a full range of contraceptives.

2. Maternal care, including prenatal, delivery and post-partum care, as well as essential obstetric care.

3. Prevention and treatment of reproductive tract infections, including sexually transmitted diseases, prevention of HIV/AIDS, and availability of affordable condoms.

4. Access to quality services for the management of complications from unsafe abortion (in circumstances where abortion is not against the law, such abortion should be safe) and post-abortion family-planning counselling and services.

5. Information, education and counselling on human sexuality.

6. Referral for these and other conditions, such as breast cancer, cancers of the reproductive system, and infertility.

Rights and principles

Reproductive rights should be a fundamental basis of all programmes and policies. Reproductive rights include:

1. The right to freely decide the number and spacing of children, and to have the information and means to do so.

2. The right to attain the highest standard of sexual and reproductive health.

3. The right to make decisions concerning reproduction free of coercion, discrimination or violence.

Special needs

1. Eliminate discrimination against girls and women.

2. End all harmful practices, including female genital mutilation.

3. Ensure quality care for victims of sexual abuse or violence.

4. Provide adolescents with appropriate sexual and reproductive health information and services.

5. Develop innovative sexual and reproductive health programmes to reach them.

Actions

1. Promote reproductive health and rights throughout national policies and programmes.

2. Give reproductive health high priority in national agendas and budgets.

3. Launch education programmes to increase gender sensitivity, eliminate violence against women and children, and raise awareness of sexual and reproductive health and reproductive rights.

4. Empower women from a young age to exercise their rights, especially through education, and enable pregnant adolescents to continue their schooling.

5. Improve the quality of services, including better training and interpersonal skills, availability of reliable supplies and equipment, monitoring and supervision, and expanded reproductive choices.

6. Stress sensitivity to gender issues and the needs and perspective of adolescents in the training of health-care providers.

7. Integrate services to maximize use of resources and improve access.

8. Support research to improve sexual and reproductive health.

Working together

1. Involve all levels of society in making reproductive health and rights for all a reality.

2. Mobilize partnerships between Government and civil society, including non-governmental organizations and the private sector.

Implementation

In September 1994, at the International Conference on Population and development, Governments reached consensus and committed themselves to a Programme of Action that places reproductive health and rights at the centre of the population and development agenda. The implementation of the Programme of Action is the right and responsibility of each country, in accordance with its national priorities, needs and cultural context.

Notes

a/ Issued jointly be the United Nations Population Fund, the World Bank and the World Health Organization.